

JUNE 1993

# **AIDS: An Expanding Tragedy**

**The Final Report of the  
National Commission on AIDS**

**National Commission on AIDS**

WASHINGTON, DC • UNITED STATES OF AMERICA

The National Commission on Acquired Immune Deficiency Syndrome (AIDS) was established by Public Law 100-607 "for the purpose of promoting the development of a national consensus on policy concerning AIDS and of studying and making recommendations for a consistent national policy" concerning the HIV epidemic. The Commission is a bipartisan body whose members were appointed by the President, the United States Senate, and the United States House of Representatives. Five permanent members of the Commission were appointed by the Senate, five by the House, and two by former President George Bush. In addition to these twelve voting members, the Secretaries of Defense, Health and Human Services, and Veterans Affairs serve as nonvoting members of the Commission.

Under its legislative mandate, the National Commission on AIDS will cease operation on September 3, 1993. After that time, Commission reports can be obtained through the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, Maryland 20849-6003, Tel. 1-800-458-5231, TDD 1-800-243-7012. Official records of the Commission and the proceedings are lodged within the National Archives and Records Administration, Office of Federal Records Center, Washington, DC 20408, Tel. 202-501-5425.

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## PREFACE

Composing a "final report" on a massive, dynamic, and unstable epidemic as it engulfs our nation and the world is like trying to take a snapshot of a tidal wave: its pace and scope defies capture. The enormous burden of grief and loss that AIDS will impose on our society has yet to be felt fully, and the work in care, prevention, and research must be not merely sustained but accelerated just to keep pace.

The National Commission on AIDS has completed its four-year assignment to advise our government and our nation on issues and needs arising from the AIDS epidemic. We have listened to literally thousands of concerned Americans in dozens of hearings and site visits across the country, made recommendations on critical issues, and worked hard, with occasional success, for their adoption. However, our authorization expires in September 1993 and we will cease our contributions to that Herculean task. Thus, despite the enormity of the work remaining to be done, this report is truly final so far as our specifically mandated efforts are concerned.

This is a short, sometimes angry report tinged with sadness and foreboding. It is short, because all of what we say here has been said many times before. It is sometimes angry because the carefully considered, widely heralded recommendations contained in our previous reports have been so consistently underfunded or ignored. It is sad because a potentially preventable disease continues to expand relentlessly and cause loss of life in young Americans on an unprecedented and unacceptable scale. The human immunodeficiency virus (HIV) has profoundly changed life on our planet. America has not done well in acknowledging this fact or in mobilizing its vast resources to address it appropriately. Many are suffering profoundly because of that failure, and America is poorer because of this neglect. We are apprehensive because the situation will inexorably worsen without immediate action.

So in this last document we will offer a snapshot on the current location of the "tidal wave," suggest a series of principles that should underlie the mobilization of the response required to contain the epidemic, and close with two broad recommendations that could start that mobilization process. We refer the reader to our previous reports for details on how better to confront the epidemic in ways that could minimize the damage of the tidal wave.

We end our four years' work hoping for a new era.

June E. Osborn, M.D.  
*Chairman*

David E. Rogers, M.D.  
*Vice Chairman*



## ACKNOWLEDGMENTS

A few words of acknowledgment cannot capture the degree to which the Commission and its staff are indebted to the legions of people who, in so many ways, helped us execute the legislative mandate for our work over the past four years. Similarly, to list names would surely miss some among the thousands we encountered along the way; they provided us with critical insights and kept us going when our energy was low. Therefore, it is more appropriate for us to thank all Americans concerned about AIDS for sharing, in one way or another, their wisdom and experience with the Commission. But particular thanks must go to those living with HIV for their special insights.

The Commission and staff also wish to offer their thanks for the opportunity to serve the nation in confronting this pandemic.

# AIDS: An Expanding Tragedy

## Introduction

Two years ago, when the National Commission on AIDS prepared its report, *America Living with AIDS*, we tried to shout a warning to our nation that would reverse a decade of unreasoning fear and cruel indifference to the AIDS epidemic, an historic health disaster that threatened all of us. We gave voice to our sense of urgency, saying, "... in the months to come [the people of the United States] must either engage seriously the issues and needs posed by this deadly disease or face relentless, expanding tragedy in the decades ahead ...."

But alas, our nation has continued on that short-sighted course. Sadly, we must continue to report that America is still doing poorly. Our warnings have fallen far short of their intended effect. The epidemic numbers continue to expand, the trends toward universality of involvement have intensified, and the ghastly twin epidemics of AIDS and drug abuse have been joined by a third deadly fellow traveler—tuberculosis.

There has been some progress. The definition of AIDS has been expanded to represent more accurately the lethal swath of disease from the human immunodeficiency virus (HIV), especially among women and minorities. But even before that extended definition influenced the statistics, more than a quarter of a million Americans had been diagnosed with AIDS in just the first twelve years of the ongoing epidemic. Cumulative mortality now exceeds three times the toll of American deaths exacted in the Vietnam War. Efforts to care for people living with HIV and AIDS have been hampered by consistent underfunding at the federal, state, and local levels—and this underfunding grows worse.

More and more the claim that "AIDS is just one disease" is used to argue that we should divert funds to other concerns. Yet it is an epidemic disease, a potentially preventable deadly infection for which there is only palliative treatment, no cure, no vaccine, and it is *not* under control. Moreover, it typically strikes in the prime working years of life. Relative to other health concerns HIV disease continues to increase. The failure to respond adequately represents at best, continued dogged denial, and at worst a dismaying hidden and unvoiced belief that this is "just" a disease of gay men and intravenous drug users, both groups that are perceived as disposable. One would not have heard such comments during the years before poliomyelitis was contained—and yet there were more cases of AIDS diagnosed last year in the United States than there were cases of paralytic polio in the worst epidemic summers before the advent of the Salk or Sabin vaccines.

The results of this denial are tragic. Homelessness is an increasingly visible consequence of HIV disease, as young people exhaust their resources and fall below a subsistence level of income. The pace of research is hampered by underfunding, and drug costs remain astronomical. The behavioral research needed to understand better how to prevent HIV infection is almost nonexistent. Funds for acute care and facilities or services for long-term care are in cruelly short supply.

*Despite billions spent on the "War on Drugs," addiction treatment on demand is not available to the vast majority of people who need it, and state laws that prohibit the purchase of syringes and needles have not been repealed despite the fact that such laws obviously incite the sharing of drug paraphernalia, which efficiently transmits HIV.*

MATHILDE KRIM, M.D., Ph.D.  
November 1992

After its comprehensive report two years ago, the efforts of the National Commission on AIDS continued to meet with complacent unresponsiveness. To eight urgently reiterated recommendations presented directly to the Secretary of Health and Human Services in the summer of 1992, the official response was that enough was being done. Despite a strongly worded plea for facilitation of housing support for people living with AIDS, there was no response at all from the leadership of the Department of Housing and Urban Development. To date, no opportunity has yet been found to discuss six recommendations sent to President Clinton upon his taking office.

The strong recommendation of both this Commission and its predecessor that drug treatment on demand be available for addicted persons resulted in only marginal increases in prevention treatment slots, while interdiction at the borders, although shown to be singularly ineffectual, and other coercive efforts continued to receive the major share of drug funding.

Perhaps most tragic, federal funds for prevention have been essentially level in recent years—and were actually cut in the 1992 budget. Further functional diversion was implicitly sanctioned through a federal directive to transfer AIDS funds to the response to tuberculosis. Thus, although HIV was creating by far the richest substrate on which the newly revived tuberculosis epidemic could thrive, expenditures to prevent it decreased.

So there is an urgent need for the people of the United States and their leadership to play catch-up. Past inattention has already exacted prices that are painful to enumerate, including such problems as:

*No one would suggest that we reduce the surgeons' fees for cutting out someone's lung so that we can pay for ads to encourage people not to smoke. No one makes that kind of connection.*

*But the fact of the matter is that in AIDS, I believe, both federally and at the state level, people are [regrettably] making these trade-offs all the time.*

MARK SMITH, M.D., M.B.A.  
January 1992

- The tuberculosis crisis, especially that involving multiple drug resistance, which arises from a synergy of neglect: neglect in the early 1980s of the public health system that had controlled TB in prior decades, neglect of the need for proper housing, neglect of the need to intensify research on new TB therapies, and neglect of the health care system in correctional facilities.
- The failure to prevent substance abuse, to provide treatment for drug users, and to implement programs for safer injection has left a legacy with "flash fire" potential for HIV transmission.
- The nation's beleaguered public health system, neglected in the 1980s and increasingly burdened with unreimbursable care for the indigent, which is in poor shape to carry out its primary public health and disease prevention role.
- The neglect of teaching tolerance and compassion, which has allowed homophobia to fester, "gay bashing" to increase, and discrimination to flourish.
- The neglect of basic health services for communities of color, which has left a legacy that now makes prevention efforts more difficult.

- The neglect of education and building of decision-making skills for adolescents concerning sexuality, which has left them at high risk of pregnancy and sexually-transmitted diseases (STDs).

Strong, positive leadership is needed to overcome entrenched ignorance and fear, as well as to rectify the serious flaws and deficits in care and prevention strategies. We are witnessing an expanding national disaster, and there is greater urgency than ever to mobilize against the scourge of AIDS.

New hope surged with the election of President Clinton. During the campaign he indicated that he grasped the scope and urgency of the HIV/AIDS epidemic, and that he intended to pursue an aggressive set of policies in response to it. Indeed, there was concern immediately after his election that the very high expectations engendered by the advent of a new and activist administration might be almost self-defeating. As one observer put it, it had taken a long time to create such a vast swamp of neglect, so it was sure to take a while simply to drain that swamp before real headway could be made against the fundamental dynamics of the epidemic's progress.

Now there is cause for serious concern that response to the epidemic is again tangled in politics. To the shame of the nation and the embarrassment of the scientific community and the public health sector, HIV remains one of the diseases that bars immigration and mandates deportation. President Clinton's commendable request for supplemental FY 1993 funding of the Ryan White CARE Act has been—at least for the moment—capsized along with the President's proposed job stimulus package in which it was legislatively housed; implementation of the promised coordination of AIDS activities within the executive branch has yet to materialize. Meanwhile, the clock ticks ominously. Delay in response to AIDS inevitably spells further expansion of the scope of future trouble. Hope was fueled, however, by the Presidential budget request for FY 1994 that proposed significant increases for the Ryan White CARE Act, prevention and research. This request needs complementary action by Congress but is, in itself, an encouraging signal. Another hopeful note is the movement toward universal health coverage, but that is muffled by concern that the transition will take longer than those with AIDS have to live.

In this final report of the National Commission on AIDS we attempt to accomplish several limited objectives. First, we will briefly summarize projections of the future scope and dynamics of the spread of HIV and its destruction of human life over the remainder of the decade. We will not project further, since we strongly believe that the future magnitude of diseases can be influenced by preventive actions taken now. We will also summarize current best thinking about the uncertain prospects for therapy, cure, and vaccine in the remainder of the decade. We will project the need for expanded efforts to care for the vast numbers of young adults who assuredly will become ill during that time period.

We will close with a short set of principles that must underlie revitalized efforts to control the epidemic and care for people living with HIV, as well as some broad recommendations for immediate action to be taken in order to position the nation more appropriately for what promises to be a long, arduous struggle with HIV disease into the next century.

Detailed recommendations concerning specific topics related to the epidemic are contained in one or more of the 15 reports published by the National Commission on AIDS since it began its work in August 1989. These reports are indexed in Appendix A.

*A tremendous reservoir of decency and good will is ready to be tapped by a humane and visionary administration.*

SANDRA SINGLETON McDONALD  
November 1992



This report is our final heartfelt public plea that this nation face squarely and forthrightly the implications and the magnitude of the human disaster created by HIV infection and AIDS. We call on the President to develop a comprehensive national plan to deal with it effectively. We call on Congress to fund the research necessary to achieve better preventive and therapeutic solutions to it. We call on the President and Congress to design and underwrite a responsive system of health and medical care for all HIV-infected people who need it. And we call on all Americans to work single-mindedly to lessen the cruel discrimination that has added such horror to the lives of those infected. As a nation we can do vastly better in confronting this crisis than we have to date.

## The Future of the HIV/AIDS Epidemic

As the second decade of the HIV/AIDS pandemic progresses, it becomes increasingly clear that it will alter the course of many societies. It is worth a brief attempt to outline projections for the United States and the world to the year 2000.

As of April 1993, a cumulative total of 289,320 AIDS cases and 179,748 deaths from AIDS had been reported to the Centers for Disease Control and Prevention (CDC, 1993b). In 1992, 47,106 newly diagnosed AIDS cases and 29,763 deaths were reported by year's end (CDC, 1993a), but the number of deaths from AIDS in 1992 is expected to rise to around 50,000 as statistics are updated. These awful numbers are in all likelihood lower than the actual toll, both because only about 80 percent of cases are officially reported to CDC and because many people have died of HIV-related disease that did not meet earlier definitions of AIDS.

The number of persons meeting the 1987 criteria for AIDS diagnosis is anticipated to increase from 58,000 in 1991 to approximately 70,000 annually during the next two or three years. Due to longer survival after diagnosis, the numbers of people living with AIDS will increase as well—from 90,000 in January 1992 to 120,000 in January 1995. The number of new AIDS diagnoses among men who have sex with men and among injection drug users is projected to remain level during this period. However, AIDS diagnoses among persons whose infection is due to heterosexual transmission is likely to continue to increase (CDC, 1992). To date, nearly half of all AIDS cases have occurred among African Americans and Hispanics, although they make up only 21 percent of the overall population (CDC, 1993a). This disproportionality is expected to increase in future years.

In January 1993, CDC adopted an expanded AIDS case definition that took into account severe immunosuppression *per se* and added recurrent bacterial pneumonias, pulmonary tuberculosis, and invasive cervical carcinoma in HIV seropositive people to the long list of AIDS-defining conditions. That change will increase the absolute numbers of AIDS cases reported in the next few years, particularly among drug users and women, compared with projections that used the 1987 definition. In the past, many people died with severe immunosuppression but without meeting criteria for AIDS diagnosis, so this change will increase the accuracy of the mortality toll.

AIDS diagnoses, of course, tell a story that is out of date, since it takes an average of 10 years between onset of infection and appearance of AIDS-defining disease manifestations. Present CDC estimates suggest that at least one million people are infected, so that during the remainder of the decade the annual number of new AIDS diagnoses will remain high, probably at between 40,000 and 80,000 per year. Indeed, even if there were no new instances of infection from now on, the nation would be severely challenged just

*The physician attending told her [JG] that these were not HIV-related, and that the clinic had no gynecological provider anyway. "JG" did not have time to find another doctor or to work up the nerve to question her doctor further about these gynecological conditions.*

*She died a week later, after waiting hours in an emergency room, of septicemia caused by massive pelvic inflammatory disease.*

THERESA MCGOVERN, J.D.  
December 1991

to meet the care needs of those already infected. Yet new infections will continue unless we do far better at prevention, and of course their impact will extend beyond the year 2000.

### Trends in U.S. HIV Incidence and Prevalence

As noted, the spread of AIDS among heterosexuals will account for all increasing percentages of new AIDS diagnoses in upcoming years, and thus care of women and children will present a more prominent need in the epidemic. With injection drug use and sexual transmission fueling that dynamic, births to infected mothers will result in more HIV-infected infants, and the death of infected mothers and fathers will result in growing numbers of "AIDS orphans." This has been the case already along the East Coast and is a dreadful problem in many countries around the world.

Some significant shifts are taking place in new HIV infection patterns compared with the pattern of AIDS to date. While HIV transmission among older men who have sex with men is sharply reduced from the early 1980s, transmission continues at high levels in younger gay men where a "generation gap" seems to have led to rejection of warnings from survivors of the first tragic decade. HIV transmission through injection drug use continues to pose a threat of "flash fire" spread of infection among drug users, through multiperson use of injection equipment, which can be followed by sexual transmission to their partners. Noninjecting drug use—especially of crack cocaine but also of alcohol—is a significant risk behavior for transmission, either from exchange of sex for drugs or impairment of behavioral decision making.

Expansion of the base of the epidemic, in large part through spread among heterosexuals, continues to gain ground, particularly among communities of color, women, and adolescents. AIDS cases in people exposed through heterosexual contact increased 17 percent in 1992 (CDC, 1993a). AIDS cases among women increased by 9 percent between 1991 and 1992, compared with 2.5 percent among men (CDC, 1993a); and in some "snapshots" of HIV prevalence among adolescents, HIV infection had a one-to-one ratio of women to men, as it does throughout much of the world. The

disproportionate representation of communities of color is at its most striking among women and children; while African American and Hispanic women make up 21 percent of all U.S. women, they constitute three-quarters of women diagnosed with AIDS. Among infants born with HIV infection due to drug use by their mothers or her sex partner, about 85 percent are African American or Hispanic (CDC, 1993a).

Trends in HIV transmission among adolescents raise particular concerns. Between 1991 and 1992, AIDS cases among people 13 to 19 years of age arising from heterosexual HIV transmission increased by 65 percent; and increasing numbers of men and women in their twenties are developing AIDS, signifying infection in their teenage years (CDC, 1993a). Among African American and Latino youth in the northeastern United States, 1 in 40 Job Corps applicants between 13 and 21 years of age was infected with HIV; and among teens aged 16 to 17 in the southeast, more females than males were infected (St. Louis et al., 1991).

The potential for spread of HIV is made clear by recent studies that estimated that 25 percent of the population were likely to have a sexually transmitted disease at some point in their lives (Donovan, 1993). Furthermore, CDC has found that about 75 percent of

*When I found out I was HIV positive, I was lost. There were very few places that I could go to get help. Because even the places that were used to dealing with people with HIV, they were not surprised to hear I was HIV positive. They were surprised to see that I was 18 years old and that I had the virus.*

PEDRO ZAMORA  
May 1992

graduating high school seniors were sexually active, while studies of condom usage revealed mostly inconsistent or no use (Curran, 1992). Adult risk of sexually transmitted diseases including HIV was illustrated by one recent survey that found that between 15 percent and 30 percent of a large survey sample reported unprotected sexual intercourse with multiple partners (Catania et al., 1992). Nevertheless, among the heterosexual population, disbelief and denial persist; in another recent study, condom use was less than 20 percent in risky sexual encounters (Catania et al., 1992). Clearly, many individuals do not recognize or take action to reduce their vulnerability to infection and probably many parents believe mistakenly that their children are not at risk.

### **HIV as an International Problem**

The crisis faced in the United States has its counterpart in virtually every country in the world. Spread of HIV varied by a few years from one region to another, but by now there is no place free of the virus. The global number infected may double or triple by the year 2000 (WHO, 1993). Denial has been a regular component of initial national response virtually everywhere, but many countries have overcome that first reaction and have mobilized in ways that need to be shared with others. The United States, by virtue of its early involvement, its biomedical research capacity, and the experience accumulated by many agencies and community groups in responding to the crisis, is in a position to be helpful; but we have also ignored some important lessons and thus are also in a position to learn from nations that have mobilized more effectively. All nations would benefit from a greater sharing of expertise and experience.

The international impact of HIV disease will expand dramatically in upcoming years, and with it will come the need and obligation to share progress in research, therapeutics, and vaccines as they develop. Notwithstanding its members' personal and collective concern for the situation abroad, our major task as a commission has been to focus on issues within the United States. It is our clear national obligation, however, to participate in a global response that is equitable, compassionate, and founded on a fundamental commitment to human rights.

### **Prospects for Prevention through Behavior Change**

We must use the tools that are available now to confront the epidemic, especially since prospects for cure or vaccine are distant. Much success has been achieved in demonstrating the feasibility of preventing HIV transmission through interventions directed at reducing risky sexual or drug-injecting behavior. In general, successful research or pilot/demonstration projects have been targeted to particular groups (for example, older men who have sex with men, runaway street youth, early to mid adolescents, or injection drug users). These projects have enabled the identification of general principles and practices of intervention likely to predicate success.

It has become clear that, to be successful, HIV prevention efforts need to provide information, build skills to reduce risk, and provide easy access to the means to do so, for example, access to condoms and sterile injection equipment. They must also be culturally sensitive, reiterated, sustained over time, and complemented by broader efforts over the long haul, both to change behavioral norms within communities at risk and to empower individuals to change. It is also clear that those at highest risk *can* be reached

*What we really want is technology to save us and we have this firm wonderful hope in technology, rather than changing our behavior. We don't believe in behavioral interventions. We just don't think people can change their behavior. We don't believe it. But we need to believe it, because it works. It does work.*

JAMES W. CURRAN, M.D., M.P.H.  
March 1993

and will change behavior in significant numbers if appropriate motivations are identified, explicit and targeted campaigns are developed, and natural and credible channels of communication are used. However, many more people need to be reached. The number of people at some degree of risk is large and the future patterns of the epidemic will make it more and more difficult to "target" them if we do not intensify efforts at prevention now.

Evidence to date has taught that prevention will be most effective when specific communities are involved in all facets of planning and implementation; the only way to communicate effectively with each cultural group what we know about avoidance of HIV disease is to use the language and vernacular of the intended audiences. Thus, community involvement is critically important to the success of prevention programs. In this context, technical assistance programs must be expanded so that prevention workers are kept at the cutting edge of progress in effective intervention.

Present knowledge about the feasibility of achieving behavior change is already such that the prediction of 40,000 to 80,000 new HIV infections per year should be unacceptable. HIV is preventable, and increased resources must be devoted to prevention as well as to research to make such efforts more effective.

### **Prospects for Therapy and Cure**

The very nature of HIV infection—in which the virus' genetic material is woven into the DNA of cells—makes true cure difficult to imagine, once infection is established. The cells infected by HIV are important in their immune system and neurologic function, so destroying infected cells in order to get rid of the virus is not a realistic approach. Thus far the antiviral treatments available against HIV (AZT, ddI, and ddC) all work by inhibiting a viral enzyme necessary for replication; but while those drugs enhance well-being and delay onset of severe disease, their effect is finite and patients ultimately become refractory to them. In addition, HIV has shown the ability to develop resistance to the drugs themselves.

Potential new antiviral drugs and strategies are under development now, but most of them are still at the test tube stage, where their effectiveness and toxicity in patients cannot yet be gauged. Thus, while progress can be expected in the range of treatments available, truly curative therapies are unlikely in the foreseeable future and improvement in clinical strategies will be incremental.

It is important, during this frustrating interval of drug development, that treatment and prophylaxis of the opportunistic infections and tumors suffered by people with AIDS be advanced. The treatment of these complications of immune suppression present complex research challenges as well, but progress to date has been highly significant in improving the quality of life and extending the survival of people with HIV disease, and it is important that progress in the availability and use of such drugs continue to be given major priority and attention.

### **Prospects for Prevention by Vaccine Prophylaxis**

Evidence from animal model research over the past few years has suggested that a vaccine against HIV may be possible. While many legitimate possibilities are under investigation, there is not yet agreement among researchers as to the most promising approaches for a vaccine that would protect humans. Thus, the vaccine effort must be pursued energetically and on a broad front.

While laboratory work is progressing, however, it is important that strategies and plans for testing HIV vaccines be carefully developed so that they can be activated as soon

as promising candidates appear. Work will almost surely have to be undertaken both in the United States and in other countries to assess the efficacy of such vaccines, so the planning must be done cooperatively. Early planning for possible distribution of an effective vaccine is also desirable.

Regardless of vaccine progress, however, it is imperative that behavioral and educational approaches to HIV prevention be maintained, since even an ideal vaccine would only serve as a supplement to the fundamental prevention strategies already at hand. It is particularly important to reiterate this point, since fully tested vaccines of any sort for general use are certain to be at least five to ten years off. In the meanwhile, we already know what is needed to help people avoid HIV. It would also be highly unrealistic to believe that the future availability of a technological prevention option would eliminate the necessity of behavioral prevention and care.

### **The Expanding Demand for Care and Support of Persons with HIV Disease**

To the extent that care of people with HIV disease is already difficult within the unwieldy health care system, greater stress can be predicted in the near future for a number of reasons. The increasing disproportion of people of color, many of whom are already caught in a web of poverty and disadvantage, will apply pressure where health care resources are already at the point of collapse.

The expansion of the AIDS case definition in 1993 will accelerate the identification of people living with HIV in its earlier stages, making feasible the "early intervention" strategies that have been shown to extend and enhance the quality of the lives of such people. However, the arrangement for such anticipatory care will add further stress to the system.

The management of HIV disease is likely to become more complex: combination therapy and prophylaxis will both become more common. Use of new diagnostic technologies (as, for instance, for antiviral resistance) will probably increase. The number of persons for whom support—such as home care, child care, and transport—will make the difference between indigency and continued productivity will increase sharply. The number of persons with tuberculosis (both those with HIV and those with tuberculosis alone) will increase. These people will need early diagnosis, and their treatment must be carefully monitored and sustained to avoid creation of multiple-drug-resistant strains.

Increasingly, whole families will be affected by HIV disease; not only will HIV-infected children and their parents need clinical care and social services, but the welfare and psychological needs of orphans must also be met.

### **Altering the Future Course of the Epidemic: Neglected Strategies**

There is much that could be done, even with present knowledge, that could soften the impact of the epidemic. Major benefits can be achieved in a synergistic, cost-effective manner through coordination and consolidation of HIV/AIDS-related programs with other health care and public health activities. For instance:

- *Coordinated planning.* The substantial benefits of information exchange and coordination of activities among federal, state, and local government agencies

*We would be extremely hard-pressed to meet the likely added service demands resulting from the proposed revision of the case definition. It has been suggested that this might itself be a way to drive increased funding for such services. I think that would require a leap of faith that the history of health care, particularly health care for people of color, women and substance users and low-income people, simply does not allow us to make. The more likely scenario would be increased need and shrinking resources.*

RON JOHNSON  
December 1991

*People are not just "doing drugs." There is some real pain going on in people's lives. And this needs to be addressed. I think historically this country has never considered the emotions of real people, of poor people. They have never considered us as people.*

JANICE JIRAU  
January 1992

*And yet, when I look at the data that were collected just last year by the Centers for Disease Control that suggest that 38 percent of black Americans who responded to the National Health Survey believed still that HIV infection can occur from mosquitoes and that 20 percent were not sure; that 39 percent of the Hispanics who responded believed that mosquitoes are likely to be able to infect people with HIV, and 18 percent were not sure—these data alone suggest the fact that the time for HIV and AIDS 101 is not over. We have such a long way to go despite what we might believe for the general population.*

JACOB GAYLE, PH.D.  
January, 1992

and the private sector (such as community-based organizations and workplace planners) unfortunately have not been achieved to date. It is in this context that the National Commission on AIDS has called for development of a national strategic plan; we continue to do so, since the quality of epidemic response, as well as inherent savings, could be significantly enhanced.

- *Comprehensive reform of the national health care system.* HIV disease (and other chronic diseases) should be carefully factored into the design of health care reform proposals. Universal access to coverage for a continuum of comprehensive services including home care and long-term care, and support of case management approaches are key ingredients in such reform.
- *Human resources planning for underserved communities.* Overall health manpower needs should be assessed in light of the upcoming pressures of the epidemic. As noted, these are likely to be at their least adequate among populations at greatest need.
- *A more effective drug policy.* The crucial variable represented by substance use in determining the scope of the future epidemic must be grappled with realistically. An approach that emphasizes "harm reduction," for example, access to sterile injection equipment, is essential: this would not only prove more humane and effective in controlling drug use *per se* than the past "war on drugs," but would also yield dividends in reduced HIV and tuberculosis transmission. Resources should be shifted from interdiction and mandatory punishment toward drug treatment availability for all who seek it.
- *Housing, rather than hospitalization, for people with HIV.* More flexibility and attention by the Department of Housing and Urban Development regarding the housing needs of people living with HIV would diminish the problems associated with homelessness, which is a frequent consequence of illness and loss of income in poorly insured young adults. In particular, unnecessary hospitalizations can be substantially reduced by assuring stable housing arrangements appropriate for people with HIV disease.
- *Educational efforts to increase understanding of HIV disease.* Discrimination, stigmatization, or other callous and inappropriate responses to people living with HIV often arise out of unwarranted fear from lack of knowledge. Increased general awareness of basic facts can reduce such ignorant responses substantially and lay a foundation for preventive efforts. Public education should be redesigned and intensified with these goals in mind.

- *Adolescent health initiatives.* School-based health programs can provide a particularly effective resource for assuring access to basic health education and services for underserved adolescents. In addition to teaching about HIV and other STDs, information about teenage pregnancy, awareness of substance abuse hazards, nutritional knowledge, and other fundamental health skills can be conveyed in such a setting to teens whose home environments are deficient in such knowledge. Issues such as "safer sex" strategies must be dealt with in a manner acceptable to communities in which the programs are housed; but lack of access to such information can be life-threatening to youth at risk, and school-based health programs have yielded promising results to date.
- *Support for community-based organizations, providers, and volunteers.* The key role of community-based organizations in responding to the complex needs of people living with HIV must be acknowledged and fostered. The history of response to the epidemic in the United States includes countless instances of community-based leadership and individual heroism without which the present picture would be much bleaker. The effectiveness of such organizations reflects their critical links with and trust from the community, whether the community is defined by ethnicity, geography, or sexual orientation. Of equal importance is the commitment of community workers—often volunteers. Such crucial functions must be sustained through enhanced mechanisms for funding, technical assistance, and recruitment of other organizations (especially religious groups or those in the workplace) not yet optimally involved.



## Principles to Guide the Future Response to the Epidemic

While a series of clear and present steps are needed to initiate a more aggressive approach to the HIV epidemic, the Commission believes certain general principles can serve as a compass that can help guide the national response. Not all are AIDS specific.

1. Leadership is essential. Leadership in any context entails developing a vision of the response needed, establishing a plan to realize it, and accepting responsibility for its fulfillment. Leadership in the response to AIDS also provides the visible affirmation of the inclusion of people affected by HIV disease in the community.
2. Access to basic health care, including preventive, medical, and social services, should be a right for all. Our nation must find ways to finance that care for all.
3. The United States must have a vital and responsive public health system. This means rebuilding an adequately supported public health "infrastructure" with a sufficient number of trained personnel to carry out the primary public health functions of surveillance, assessment and analysis, and prevention. All levels—federal, state, and local—must have the necessary capacity to fulfill their designated roles.
4. The best science will yield the best public strategies. But the best science cannot flourish where it is blocked or constrained for ideological reasons or political convenience. Nor can it contribute properly where it is underfunded or its lessons are ignored in program design.
5. To the greatest extent possible, health care solutions (including those for HIV/AIDS) must avoid disease specificity. Solutions should offer a broad continuum of comprehensive services to those with problems of chronic relapsing disease. Strategies should recognize that the health of entire communities is often dependent upon the health of the least advantaged.
6. Partnerships are necessary. Collaboration between levels of government, with the business community, with the religious community, with the voluntary not-for-profit sector, and with community-based organizations is essential to providing a coordinated response. A broad array of persons, including people with HIV disease, AIDS advocates, health professionals, and community representatives, must be included in formulating prevention, care, and research strategies.
7. The human face of AIDS should be ever before us. Respecting personal dignity and autonomy, respecting the need for confidentiality, reducing discrimination, and minimizing intrusiveness should all be touchstones in the development of HIV/AIDS policies and programs.

*We need a language of hope which affirms life. I didn't become uncreative or unproductive with the announcement that I had tested positive. As a matter of fact, my life is hardly over.*

*... we need a language of respect. I am not a statistic. And to reduce me to a heap of numbers is to make of me something that is no longer human.*

*Respect must affirm personhood. It recognizes and communicates that I am a mom, not a victim; a daughter, not a tragedy; a friend, not a casualty.*

MARY FISHER  
June 1992

## Recommendations

We will close with but two recommendations. They will not be unfamiliar to those who have followed our work, but we believe they are central, vital, and critical to launching a more adequate national response to the central human crisis of our times. The details of implementation are less important. Many are contained in our previous reports. But we need a new mind set, a new, less selfish national resolve, a new way of thinking about the epidemic that says this toll of human suffering and death is unacceptable to us. We need to acknowledge better the heroic contributions of those individuals and organizations who have been working so single-mindedly in the field of HIV and AIDS. Each of us must ask, "How can I be of help?"

### Recommendation 1

#### **Leaders at all levels must speak out about AIDS to their constituencies.**

Our President must speak out clearly and forcibly about the nature, extent, and needs of the AIDS disaster. This has been our foremost recommendation since 1991. One AIDS activist group has as its symbol a pink triangle with the phrase, "silence=death." There is much to suggest that they are right. The appalling lack of frank discussion about the epidemic at all levels of national leadership fostered a woefully inadequate response, yielding death and suffering well in excess of what might have been. Silence has existed at too many levels of responsibility. Few governors, mayors, members of Congress, corporate executives, community or religious leaders, have stepped forward—perhaps taking their cue from previous Presidents. Consequently, the scale of the problem is seriously underestimated, and fear, prejudice, and misinformation abound. Leaders have both the capacity and the responsibility to coalesce their communities to find solutions.

We are vividly aware of the fact that addressing AIDS—and particularly issues that require discussing sexuality or drug use—is difficult for many to deal with comfortably. Further, some of the steps that will be required to address the epidemic better will be unpleasant or unpopular in the minds of many. But to confront difficult and sensitive issues is what true leadership means and requires. It would, in our judgment, make a profound difference in our national response to HIV disease if full and frank discussion of all its implications was initiated and encouraged by those in positions of responsibility at all levels.

### Recommendation 2

#### **We must develop a clear, well-articulated national plan for confronting AIDS.**

Again, high on our list of recommendations, and that of the Presidential Commission preceding us, has been the development of a carefully crafted national strategic plan to address the issues of prevention, care, and research, required to deal with the HIV epidemic.

*Whatever one's religion or moral beliefs, there's plenty of room to teach about the danger of AIDS and how to prevent it. For AIDS is a preventable disease. Every school, church, workplace, union hall and prison offers an opportunity.*

JOSEPH A. CALIFANO, JR.  
November 1992

To this end, we have suggested such a plan directly to the President in our report, *Mobilizing America's Response to AIDS*. We have spelled out the authority and resources necessary for the coordinating office required to deal with the numerous cabinet departments that must be involved in such planning. Along similar lines, we have pointed to the singular absence of a national prevention strategy worthy of the name. We have also indicated the need for more overall planning for HIV-related research, housed appropriately within the National Institutes of Health, and the desperate need for a compassionate continuum of care for those infected. The obvious reasons for having such overarching plans, still absent in the twelfth year of the epidemic, need little further comment, except perhaps that the underlying theme of the plans should be to address sexual and drug-use behavior from a public health perspective.

*The opportunity is to deal comprehensively rather than haphazardly with the problem as a whole, to see it as a social catastrophe brought on by years of economic deprivation and to meet it as other disasters are met, with an adequacy of resources.*

STEPHEN B. THOMAS, PH.D.  
June 1992

All of our other recommendations, past or present, follow logically from the above. There is a compelling need for a functioning public health system with the ability to conduct appropriate prevention programs, free from censorship, that would serve the special needs of gay men, of lesbians, of communities of color, of those who use drugs, of women, of children, and of adolescents. The need for better therapeutic agents, long-term care, housing, social support services, and their financing—all must be embodied in those plans. Our reports to date, and most particularly *America Living with AIDS*, spell out the particulars. Clearly our work is unfinished. Although the Commission has listened diligently, considered carefully, and kept the problem of AIDS before the public, most of our recommendations remain to be implemented. But it is time for AIDS to be swept into the mainstream of America's national agenda. To continue to treat HIV/AIDS as a marginal problem gravely threatens our nation's future. Without action on our nation's

unfinished business on AIDS, we will have a continually expanding tragedy. We call on America to get on with the job. What should be done is not complicated. But it requires leadership, a plan, and the national resolve to implement it.

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## **APPENDIX A: An Indexed Guide to the Reports of the National Commission on AIDS**

**Note:** The codes used here to reference Commission reports are identified on the "Commission Documents" list in Appendix B.

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## APPENDIX B: Commission Documents

For any of the information about proceedings of the National Commission on AIDS please contact:

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Document Code Reports	Document Title
R1	First Interim Report to the President and the Congress: "Failure of U.S. Health Care System to Deal with HIV Epidemic." December 1989.
WGR1	Working Group Summary Report on Federal, State, and Local Responsibilities. March 1990.
R2	Second Interim Report to the President and the Congress: "Leadership, Legislation, and Regulation." April 1990.
R3	Third Interim Report to the President and the Congress: "Research, the Work Force, and the HIV Epidemic in Rural America." August 1990.
AR1	Annual Report to the President and the Congress. August 1990.
R4	Fourth Interim Report to the President and the Congress: "HIV Disease in Correctional Facilities." March 1991.

**Document Code  
Reports**

**Document Title**

WGR2	Report of the Working Group on Social and Human Issues to the National Commission on AIDS. April 1991.
R5	Fifth Interim Report to the President and the Congress: "The Twin Epidemics of Substance Use and HIV." August 1991.
T1	Technical Report Prepared for the National Commission on AIDS: "Financing Health Care for Persons with HIV Disease: Policy Options." August 1991.
ALWA	Second Annual Report to the President and the Congress: "America Living With AIDS." September 1991.
R6	Sixth Interim Report to the President and the Congress: "The HIV/AIDS Epidemic in Puerto Rico." June 1992.
R7	Seventh Interim Report to the President and the Congress: "Housing and the HIV/AIDS Epidemic: Recommendations for Action." July 1992.
R8	Eighth Interim Report to the President and the Congress: "Preventing HIV Transmission in Health Care Settings." July 1992.
R9	Ninth Interim Report to the President and the Congress: "The Challenge of HIV/AIDS in Communities of Color." December 1992.
R10	Tenth Interim Report to the President and the Congress: "Mobilizing America's Response to AIDS." January 1993.
R11	Eleventh Interim Report to the President and the Congress: "HIV/AIDS: A Challenge for the Workplace." June 1993.
R12	Twelfth Interim Report to the President and the Congress: "Preventing HIV/AIDS in Adolescents." June 1993.
R13	Thirteenth Interim Report to the President and the Congress: "Behavioral and Social Sciences and the HIV/AIDS Epidemic." July 1993.
R14	Final Report to the President and the Congress: "AIDS: An Expanding Tragedy." June 1993.

Document Code Statements	Document Title
S1	Support for Passage of the Americans with Disabilities Act. September 6, 1989.
S2	Support for Increase in AIDS Funding in the FY 1990 Appropriations Bill. September 19, 1989.
S3	Support for the Goal of Treatment on Demand for Drug Users. September 26, 1989.
S4	Support for Continued Funding of Research on Effectiveness of Bleach Distribution. November 7, 1989.
S5	Resolution on U.S. Visa and Immigration Policy. December 1989.
S6	Endorsement of Principles and Objectives of Comprehensive AIDS Resources Emergency (CARE) Act of 1990. March 6, 1990.
S7	Despite Debate Among Epidemiologist, HIV Epidemic Will Have Greater Impact in 1990s than 1980s. March 15, 1990.
S8	Endorsement of Principles and Objectives of AIDS Prevention Act (H.R. 4470) and Medicaid AIDS and HIV Amendments Act of 1990 (H.R. 4080). May 11, 1990.
S9	Statement of the Commission's Stand on Immigration. July 11, 1991.
S10	Statement of the Commission's Stand on HIV Testing in the Health Care Workplace. July 11, 1991.
S11	Brief of <i>Amicus Curiae</i> by Members of the National Commission on AIDS. <i>Haitian Centers Council, Inc. et al., v. Gene McNary, Commissioner, Immigration and Naturalization Service, et al.</i> , No. 92-6090 (2d Cir.). April 1992.
S12	Statement on the Meeting Between the National Commission on AIDS and the Secretary of Health and Human Services. June 25, 1992.
S13	Statement by Vice Chairman David E. Rogers, M.D., on the Resignation of Magic Johnson from the NBA. November 2, 1992.

**Document Code  
Statements**

**Document Title**

- S14 Statement on Strengthening the NIH Office of AIDS Research. January 28, 1993.
- S15 Statement on Immigration Policy. February 11, 1993.
- S16 Statement on GAO Needle-Sharing Report. March 25, 1993.

**Letters**

- L1 Letter to President Bush urging him to resolve visa controversy before international conferences to be held in the United States in June and August of 1990. March 9, 1990.
- L2 Letters to Senate Majority Leader Mitchell and Senate Minority Leader Dole urging Senate consideration of the Ryan White CARE Act of 1990. May 7, 1990.
- L3 Letters to Senators Kennedy and Hatch underscoring support for the Americans with Disabilities Act and declaring the amendment concerning food handlers bad public health policy. May 24, 1990.
- L4 Letters to Speaker of the House Foley and House Minority Leader Michel urging Congress to resist attempts to impose a federal mandate on states for name reporting. June 6, 1990.
- L5 Letter to President Bush and Members of Congress calling for full funding of the Ryan White CARE Act. September 18, 1990.
- L6 Letter to Charles McCance, Director of Quarantine, Centers for Disease Control, regarding the immigration issue. February 15, 1991.
- L7 Letter to Members of Congress regarding funding of the Ryan White CARE Act. June 5, 1991.
- L8 Letter to Attorney General Richard Thornburgh with accompanying letter to Secretary of Health and Human Services Louis Sullivan regarding current immigration policy. June 13, 1991.

Document Code Letters	Document Title
L9	Letter to congressional leadership regarding support for funding of behavioral and social research. July 24, 1991.
L10	Letter to President Bush from Commissioner Belinda Mason. August 1, 1991.
L11	Letter to William L. Roper, Director of the Centers for Disease Control, on policy implications of HIV disease definitions. December 12, 1991.
L12	Letter to Assistant Secretary of Health and Human Services James Mason. December 12, 1991.
L13	Letter to President Bush on the national response to the HIV epidemic. December 12, 1991.
L14	Letter to Associate Commissioner for Disability Susan Parker of the Social Security Administration. February 21, 1992.
L15	Letter to Kenneth W. Starr, Solicitor General of the United States, Department of Justice, urging action on <i>Greenberg v. H &amp; H Music Company, No. 91-1283, on petition for a writ of certiorari</i> to ensure health care insurance for those with disabling diseases, including HIV. July 17, 1992.
L16	Letter of support for Comprehensive Services for Youth Act of 1992. July 27, 1992.
L17	Letter to state health directors expressing support for report, "Preventing Transmission of HIV/AIDS in Health Care Settings." July 30, 1992.
L18	Letter to President Clinton urging airlift of HIV-infected Haitians on Guantanamo Bay Naval Base for medical care and immigration hearing. February 17, 1993.
L19	Letters to congressional leaders urging legislative action with regard to ERISA, to ensure that all persons with chronic diseases and disabilities, including HIV, will not face limitation or elimination of health insurance benefits when they become sick. March 25, 1993.

**Document Code  
Letters**

**Document Title**

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| L20 | Letters to Congressional leaders supporting the additional funds for programs under Ryan White CARE Act, included in the FY 1993 Supplemental Appropriations Bill. March 25, 1993. |
| L21 | Letters to Appropriations Committees in support of President Clinton's FY 1994 budget request for HIV/AIDS programs. April 22, 1993.   |

**Information on the Commission**

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| I1 | Commission Fact Sheet   |
| I2 | Individual Commissioner Biographies (See Appendix G)                              |
| I3 | Public Law 100-607 (Creation of the National Commission on AIDS) (See Appendix F) |



## **APPENDIX C: Cumulative Recommendations**

### **Interim Report Number One: Failure of U.S. Health Care System to Deal with HIV Epidemic (7 pp.) December 1989**

#### *What is Needed?*

FIRST, frank recognition that a crisis situation exists in many cities that will require extraordinary measures to overcome. Significant changes must be made not only in our health care system but in how we think about the system and the people it is designed to serve. As one witness told the Commission, it can no longer be "business as usual."

SECOND, the creation of a flexible, patient-oriented, comprehensive system of care, closely linking hospital, ambulatory, residential, and home care. Primary care physicians must be central to such a system. But if primary care doctors are to care for patients with HIV infection and AIDS, they need the financial, social, and institutional support to assist them in managing complicated patients.

THIRD, consideration of the creation of regional centers of networks of care, perhaps using the already existing regionalized hemophilia treatment program as a model. These centers would not serve as a replacement for the care provided by primary care physicians but would provide backup and consultation to help strengthen community-based primary care.

It is essential that everyone be afforded early intervention and access to care. In addition, the availability of backup and consultation from appropriate specialists is required to provide the assistance and encouragement primary care doctors need to see more people with HIV infection and AIDS. Regional centers should also provide the appropriate link with the hospital when hospital services are needed.

FOURTH, create units which can treat patients who have both HIV infection and drug addiction. The availability of drug treatment on request is essential for responding to the combined HIV and drug epidemic that imperils not only drug users but also their sexual partners and children.

Given the massive link between drug use and HIV infection, and the fact that there is an alarming increase in the number of new infections among intravenous drug users, the Commission wishes to go on record in expressing its surprise and disappointment that the White House National Drug Control Strategy mentions AIDS only four times in its ninety pages of text and not at all in its recommendations or discussions of how to allocate resources. The President's drug strategy simply must acknowledge and include HIV infection and AIDS.

FIFTH, provide comprehensive health care services under one roof. Fragmented services create additional barriers to needed health care. Often mothers will seek health

care services needed for their babies but are not able to then gain access to care for themselves. Health care services for women and children need to be provided in one place. For the homeless, housing and health care need to go hand in hand. This is true not only for those who are homeless today but for those who will become homeless tomorrow because of the HIV epidemic.

**Working Group Summary Report: Federal, State, and Local Responsibilities  
(11 pp.) March 1990**

1. Efforts in the public sector at all levels of government should be guided by broad policy goals.

The Working Group suggested that the policy goals identified by the National Association of Counties Task Force on HIV Infection and AIDS could serve as a model for all levels of government. These goals are:

1. to end the HIV epidemic through prevention, education, and research;
2. to assure access to treatment, care, and support services for all persons with HIV infection;
3. to protect the civil rights of all citizens; and
4. to assure adequate funding for a continuum of HIV prevention, treatment, care, and support services and HIV research through effective public sector (federal, state, and local government) and private sector leadership and partnership.

2. Federal, state, and local governments should develop comprehensive plans for implementing identified goals. These plans should be developed in response to the policy recommendations of the National Commission on AIDS with interagency government representation and private sector involvement, including community-based organizations and persons with HIV disease.

The Working Group strongly recommended that the federal government should immediately develop a forceful comprehensive national HIV plan addressing prevention, education, treatment, care, support services, civil rights, research, and funding for these activities. The President should designate the Secretary of Health and Human Services to chair a cabinet-level Task Force to develop the national implementation plan. While the National Commission on AIDS fully intends to recommend policy goals for a national plan, the Commission believes it is essential that a Task Force be in place to enhance government-wide implementation of such a plan. In this way, those who are ultimately responsible for the implementation will have had an active role in its development, thus enhancing the likelihood of implementation. The Task Force should include each Department in the federal government and should solicit input from state and local governments and the private sector, including community-based organizations and persons with HIV disease.

3. The U.S. House of Representatives should, like the United States Senate, pass the Americans with Disabilities Act and state and local governments should pass laws forbidding discrimination in areas not covered by the Americans with Disabilities Act or other federal statutes.

4. Immediate action is necessary at the federal level to assist states, counties, and cities disproportionately impacted by the HIV epidemic. "Impact Aid" disaster relief or direct emergency relief is needed to assist states and localities in developing a continuum of HIV prevention, treatment, care, and support services.
5. The issues of health care financing and health care and social service organization and delivery require a level of expertise and commitment of time that was not provided for in this working group session. The Working Group believes these issues would be best addressed by the full Commission.
6. Incentives at the federal, state, and local level need to be created to recruit, retain, and train human services personnel. The Working Group recommends that the federal government should support a National Health Service Corps approach to involving more primary care providers in the care of persons with HIV. Medicaid reimbursement rates for outpatient care should be augmented and all universities (public and private) should include HIV education in health professional education and training.
7. Federal, state, and local government should have in place policies to encourage the development of housing programs that meet emergency, short-term and long-term needs of persons with HIV. Congress should support legislation to establish housing programs that provide short-term and long-term housing with necessary support services. State legislation should encourage flexibility in developing alternative housing and residential settings. Localities need to address the "not-in-my-backyard" syndrome related to shelters and residencies, and work closely with neighborhood groups.
8. Federal, state, and local governments and community-based agencies need to develop more effective partnerships in HIV prevention, education, and information. The Working Group believes that federal restrictions on the use of education and prevention funds is counterproductive and prolongs the HIV epidemic. Restrictive legislative language appears to hinder states and localities and community-based agencies in providing the prevention message in ways that would reduce individual risk and limit the spread of HIV infection. Therefore, while states and localities should be accountable for the federal funds they receive, the use of these dollars for education and prevention programs should be flexible. Evaluation of these programs to determine what approaches work best is essential and these programs should be innovative, creative, and culturally respectful. Finally, since community-based organizations are at the heart of HIV education efforts, these agencies should be supported by all levels of government, including the provision of support for education and training of agency staff and organizational development assistance.
9. The Working Group identified substance abuse prevention and treatment as a priority area but time did not permit specific recommendations to be made. The Working Group recommends that the full Commission address this issue.

**Interim Report Number Two: Leadership, Legislation, and Regulation**  
(7 pp.) April 1990

1. The National Commission on AIDS will continue to recommend policy goals for a national plan. However, the Commission believes it is essential that a federal interagency mechanism be in place to coordinate a national plan. In this way, those

who are ultimately responsible for the implementation will have an active role in its development.

2. Federal disaster relief or direct emergency relief is urgently needed to help states and localities most seriously impacted to provide the HIV prevention, treatment, care, and support services now in short supply. The Commission strongly supports the efforts in Congress, now embodied in S.2240, to address this need. The resources simply must be provided now or we will pay dearly later.
3. Housing is an absolutely vital component of any comprehensive effort to address the multiple problems posed by HIV infection and AIDS. While the Commission recognizes that coordination between the state and local government, with input from community-based organizations, is essential to effectively respond to the homeless crisis, we also believe the federal government must take the lead in providing the dollars needed to respond to this overwhelming, indeed catastrophic, problem.
4. Government restrictions imposed on the use of education and prevention funds are seriously impeding HIV control. They are clearly serving to prolong the HIV epidemic and should be removed.
5. Because the Americans with Disabilities Act (ADA) guarantees protection against discrimination for people with HIV infections and AIDS, the National Commission on AIDS strongly urges the U.S. House of Representatives to pass the ADA in a swift and timely manner. State and local governments should pass laws forbidding discrimination in areas not covered by the ADA or other federal statutes.

#### **Interim Report Number Three: Research, the Workforce and the HIV Epidemic in Rural America (18 pp.) August 1990**

1. A comprehensive community-based primary health care system, supported by adequate funding and reimbursement rates, is essential for the care and treatment of all people, including people living with HIV infection and AIDS. The Commission highlighted this need in its first report and continues to believe that lack of access to primary care services provided by adequately trained primary care providers is undermining current efforts in HIV/AIDS research, prevention and treatment. The development of a comprehensive system with linkages to research protocols, existing community-based services, hospitals, drug treatment programs, local health departments, and long-term care facilities, based on a foundation of adequate support, is long overdue and should be a top priority for the federal government.
2. AIDS education and outreach services in rural communities should be expanded and designed to provide clear and direct messages about how HIV is and is not transmitted and the kinds of behaviors that may place an individual at risk for HIV and other sexually transmitted diseases. Expansion of programs, resources, and health care providers is also needed to respond to rural America's need for prevention and treatment programs that address the three epidemics of HIV infection, drug addiction, and sexually transmitted diseases.
3. The NIH clinical trials program is in serious trouble. The limited number of enrollees in trials and the lack of demographic and geographic diversity of the participants threatens the success of the program and denies many people living with HIV infection and AIDS the opportunity to participate in experimental drug therapies. The academic

health centers involved have not been as vigorous as one would hope in advancing these trials, nor has the NIH been vigorous in monitoring their performance. Aggressive efforts must be made to overcome the obstacles to participation of many who are underrepresented. Success in this area can only be measured by increased participation in trials.

4. There is a desperate need for more research on the management of opportunistic infections, usually the cause of death for people with AIDS. The NIH simply must expand the level of research in this area. This expansion must not come at the expense of other research efforts and should be an integral part of a comprehensive AIDS research plan. This plan should outline the AIDS research priorities and goals for the entire NIH and the resources needed to achieve them. The plan should be widely disseminated and should incorporate the views of persons living with HIV infection and AIDS.
5. There is a shortage of crisis proportions of health care providers capable and willing to care for people living with HIV infection and AIDS. This crisis will only get worse as the HIV epidemic continues into the 1990s. Action must be taken now to increase and improve the effectiveness of all programs designed to educate and retain practicing health care professionals, and to create incentives for providers to care for people in underserved areas. Existing programs such as the National Health Service Corps should be expanded. New programs such as those outlined in the Disadvantaged Minority Health Improvement Act (H.R. 3240) should be created. And, specific HIV/AIDS fellowships and training programs should be established and supported to prevent a crisis of greater magnitude.
6. Volunteers should be publicly recognized not only for the invaluable contribution they have made to people living with HIV infection and AIDS, but also for the way in which they fight fear and bigotry by fostering compassion and caring. The cost-effective dollars needed to recruit, train, support, and manage volunteers must be provided by the government and the private sector, and recognized as essential to our national response to the HIV epidemic.

**Interim Report Number Four: HIV Disease in Correctional Facilities**  
(43 pp.) March 1991

1. The U.S. Public Health Service should develop guidelines for the prevention and treatment of HIV disease in all federal, state, and local correctional facilities. Immediate steps should be taken to control the subsidiary epidemics of tuberculosis and sexually transmitted diseases. Particular attention should be given to the specific needs of women and youth within all policies.
2. Given the dearth of anecdotal and research information on incarcerated women, incarcerated youth, and children born in custody, federal and state correctional officials should immediately assess and address conditions of confinement, adequacy of health care delivery systems, HIV education programs, and the availability of HIV testing and counseling for these populations.
3. To combat the overwhelming effects which drug addiction, overcrowding, and HIV disease are having on the already severely inadequate health care services of correctional

systems nationwide, a program such as the National Health Service Corps should be created to attract health care providers to work in correctional systems.

4. The Department of Health and Human Services should issue a statement clarifying the federal policies on prisoners' access to clinical trials and investigational new drugs. In addition, the Food and Drug Administration, in conjunction with the Health Resources and Services Administration and the National Institutes of Health, should initiate an educational program directed toward informing inmates and health care professionals working in correctional facilities of the availability of investigational new drugs, expanded access programs, and applicable criteria for eligibility of prisoners in prophylactic and therapeutic research protocols.
5. Meaningful drug treatment must be made available on demand inside and outside correctional facilities. Access to family social services and nondirective reproductive counseling should also be made available with special emphasis on the populations of incarcerated women, youth, and children born in custody.
6. Prison officials should ensure that both inmates and correctional staff have access to comprehensive HIV education and prevention programs. Particular attention should be paid to staff training on confidentiality and educating inmates about the resources available in the prison setting that may be employed to reduce the risk of infection.
7. The burden of determining and assuring standards of care has largely fallen to the courts, due, in part, to the failure of the public health authorities to take a leadership role in assuring appropriate standards of health care and disease prevention for our incarcerated populations. Bar associations and entities such as the Federal Judicial Center must, therefore, establish programs to educate judges, judicial clerks, and court officers about HIV disease.

#### **Working Group Report: Social and Human Issues (38 pp.) April 1991**

##### ***Early Intervention and a Continuum of Care***

**Increased efforts must be made to reach those who have historically been denied access to health care.** These efforts must include the development and enhancement of health care and social service providers within and by minority communities.

**Meaningful early intervention is more than the provision of AZT or other drugs to those with HIV disease before they develop symptoms.** Early intervention also entails psychological support, education and counseling, substance use treatment, and social services.

**People living with HIV disease should be provided a continuum of care so that at every stage of illness they are cared for in the least restrictive setting possible, preserving the greatest degree of independence.** A responsive continuum of care will depend upon complex and intricate relationships among public health agencies, community-based and voluntary organizations, hospitals, nursing homes, and hospices.

**Comprehensive models of medical and psychosocial care for asymptomatic and mildly symptomatic individuals must be developed to ensure prevention and appropriate treatment.** Stronger links are needed among the HIV testing enterprise, the public health system, health care delivery systems, and social services. In particular, case management programs should be supported, and evaluated on an ongoing basis.

**Spiritual counseling can be a critical component of care.** Spiritual counseling should be encouraged, not only in the hospital setting, but also in the outpatient and home care environment. Professional pastoral training programs, whether based in hospitals or graduate schools, should include curricula designed to prepare trainees to care for people living with HIV disease.

**Housing tailored to a range of medical and social needs is a critical part of the continuum of care for persons living with HIV disease.** Congress should fund fully the AIDS Housing Opportunity Act of 1990.

**There is a need for a consistent commitment to provision and expansion of drug treatment.** Attention must be given to the development of care relevant to HIV disease. High-quality HIV education needs to be an integral part of all drug treatment programs. States should consider making this an explicit requirement of licensure for drug treatment programs.

#### *Delivering, Coordinating, and Paying for Services*

**Planning is key to developing a coordinated and effective response to HIV disease, and people living with HIV disease must be included in planning activities.** The planning process should be vigorously directed by the governmental agencies responsible for planning the communities' HIV response. Such planning should include the private sector and members of affected communities. The receipt of government funding should be conditional upon the establishment of relationships between service providers and affected communities.

**Leadership is essential.** Leadership entails developing a vision of the response needed to meet the challenge of the HIV epidemic in a community, developing a plan to realize it, and accepting responsibility for its fulfillment.

**Continued and increased government and private support of voluntary and community-based organizations is critical.** Fledgling organizations established more recently to meet the needs of minority communities may require special technical assistance and financial support.

**Where the appropriate governmental entity is unable or unwilling to assume responsibility for planning and coordination, voluntary and community-based organizations should coordinate local efforts to avoid needless duplication and support the creation of mechanisms to provide national volunteer leadership, technical assistance, and resource sharing.** Volunteer efforts are too important to be fragmentary and competitive.

**Cooperation and accountability is necessary in coordinating the resources of a panoply of service providers and interest groups.** Government leaders, elected and appointed, must vigorously support the coordination effort.

**The HIV disease caseload will continue to skyrocket, even if HIV disease loses its salience as a matter of public attention.** Because of the disproportionate impact of HIV and its enormous impact on already suffering communities, **the federal government has the ultimate responsibility of assuring that a continuum of medical, psychological, and social services are available to people living with HIV disease.**

### *Testing and Counseling*

It is inappropriate to create HIV antibody testing programs to identify asymptomatic individuals for therapeutic interventions unless they include plans to deliver and pay for appropriate follow-up services for a substantial majority of those screened.

**Presently available or foreseeable therapeutic benefits cannot justify mandatory testing programs.** The prospect of therapeutic benefits is not a sufficient reason for abandoning long-standing principles of informed consent.

**Long-standing principles of confidentiality of medical information should not be abandoned, especially in light of the history of discrimination against persons with HIV disease.**

**HIV antibody testing must be accompanied by pre- and post-test counseling.** People with both positive and negative results should receive counseling. For those engaging in high-risk behaviors, whether infected or not, counseling must be viewed as a sustained process. More comprehensive standards are necessary to ensure consistently high-quality counseling in a wide range of settings. More trained counselors are needed.

**Despite the potential therapeutic benefit of HIV antibody testing, there exists an array of educational and counseling interventions that can proceed independent of testing.** Much more needs to be done about education and prevention for women and people of color.

**Those who design and implement education and prevention programs must have the freedom to use explicit communication acceptable to the particular culture or group being addressed.** Sound principles of health education demand that messages which encourage behavior change be in language people understand and consistent with values they accept.

**Legal protections against discrimination and unwarranted disclosures of HIV status are even more critical as more at-risk individuals are encouraged to undergo HIV antibody testing for early intervention.** Mechanisms for the enforcement of the Americans with Disabilities Act and other anti-discrimination provisions must be put into place. In particular, state and local laws against discrimination must be rigorously enforced. Where such laws do not exist, or where they are weak, they need to be established and strengthened.

### **Interim Report Number Five: The Twin Epidemics of Substance Use and HIV (22 pp.) July 1991**

1. Expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs. Continually work to improve the quality and effectiveness of drug abuse treatment.
2. Remove legal barriers to the purchase and possession of injection equipment. Such legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new, clean injection equipment, thereby encouraging the sharing of injection equipment, and the increase in HIV transmission.
3. The federal government must take the lead in developing and maintaining programs to prevent HIV transmission related to licit and illicit drug use.



4. Research and epidemiologic studies on the relationships between licit and illicit drug use and HIV transmission should be greatly expanded and funding should be increased, not reduced or merely held constant.
5. All levels of government and the private sector need to mount a serious and sustained attack on the social problems that promote licit and illicit drug use in American society.

## **Second Annual Report: America Living With AIDS (165 pp.) September 1991**

### ***Prevention and Education***

1. **The federal government should establish a comprehensive national HIV prevention initiative.** This initiative should be authorized by Congress and developed by the Department of Health and Human Services. It should provide flexible resources to state and local government and other public or private nonprofit entities for community-wide HIV prevention efforts. It must also include input from individuals who have expertise through experience, education, or training. The prevention initiative is an essential component of a national HIV plan.
2. **Greater priority and funding should be given to behavioral, social science, and health services research.** Behavioral, social science, and health services research are currently grossly underfunded. The Commission believes there must be a more appropriate balance of funding between these areas of study and biomedical research.
3. **Congress should remove the government restrictions that have been imposed on the use of funds for certain kinds of HIV education, services, and research.** Government restrictions on certain HIV programs and on behavior-oriented research studies impede the fight against HIV disease. HIV prevention programs and research into sexual and drug-using behaviors must be conducted and evaluated. Results from these and other health promotion and disease prevention efforts must be shared and rapidly incorporated into HIV prevention and education strategies.
4. **The U.S. Public Health Service should expand and promote comprehensive programs for technical assistance and capacity building for effective long-term prevention efforts.**
5. **Federal, state, and local governments should join forces with the private sector in providing long-term support to community-based organizations.** Community-based efforts are now and will continue to be an integral part of any HIV prevention strategy. The role of people with HIV disease must be recognized, encouraged, and supported. In designing services, community-based organizations and their programs must be accountable, yet they must be afforded sufficient flexibility to implement programs that will best serve communities in need.
6. **Policies should be developed now to address future plans for the distribution of AIDS vaccines and the ethical and liability issues that will arise when vaccines become available.**
7. **The federal government should expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs.** The federal government should also continually work to improve the quality and effectiveness of drug abuse treatment.

8. **Legal barriers to the purchase and possession of injection equipment should be removed.** Legal barriers do not reduce illicit drug injection. They do, however, limit the availability of new, clean injection equipment, thereby encouraging the sharing of injection equipment, and the increase in HIV transmission.

#### *Caring for People with HIV Disease*

1. **Government should assure access to a system of health care for all people with HIV disease.** At a minimum, a system of care for all people with HIV disease should include a package of continuous and comprehensive medical and social services designed to enhance quality of life and minimize hospital-based care. States, counties, and municipalities should assure that such services are available for individuals with HIV disease. Case management programs should be available to coordinate such care. These services must include:
  - HIV antibody testing that is voluntary and must be accompanied by counseling—both anonymous and confidential testing contribute in different ways and both options should be available;
  - education and counseling to help foster and maintain behavioral changes to reduce transmission of the virus;
  - medical care, including drug therapy and frequent diagnostic monitoring, ongoing primary care, coordination of inpatient and outpatient care, access to investigational new therapies, and adequate options for long-term care;
  - psychological care, including mental health counseling and spiritual support, that is helpful in coping with a frightening and sometimes overwhelming condition;
  - drug treatment to help individuals stop using or injecting drugs or adopt safer drug use practices; and
  - social services, including a range of housing options and income maintenance, without which medical advances may be beyond the grasp of those who could most benefit from them.
2. **HIV-related services should be expanded to facilities where underserved populations receive health care and human services, in part to ensure their increased participation in trials of investigational new therapies.**
3. **HIV education and training programs for health care providers should be improved and expanded, and better methods should be developed to disseminate state-of-the-art clinical information about HIV disease, as well as drug and alcohol use, to the full range of health care providers.** The Commission believes all health care providers have an ethical responsibility to care for people with HIV disease. In order to equip providers to better counsel and care for people with HIV disease, government at all levels and local agencies and institutions must develop more effective education programs and methods for getting the information to all providers, particularly primary care providers.

Programs to train health care providers to recognize and manage drug and alcohol use must be expanded, and programs that integrate treatment of drug use with primary care must be created and supported. The Commission believes more federal funds are needed for these efforts.
4. **Federal, state, and local entities should provide support for training, technical assistance, supervisory staff, and program coordination to acknowledge and**

support the family members, friends, and volunteers who are an integral part of the care system of a person with HIV disease.

#### *Health Care Financing*

1. **Universal health care coverage should be provided for all persons living in the United States to ensure access to quality health care services.** The Commission believes universal health care coverage is a necessary step to ensuring access to quality health care. This coverage should be comprehensive and should include prescription drugs. In the interim, the Commission recommends a series of immediate short-term steps to address the urgent problem of inadequate coverage for people with HIV disease.
2. **Medicaid should cover all low-income people with HIV disease.** The Commission recommends eliminating the disability requirement and raising the income level for Medicaid eligibility for people with HIV disease. By eliminating the disability requirement, low-income people with HIV infection who have not had a clinical diagnosis of AIDS could be covered by Medicaid and receive the early intervention treatments and services they need. Increasing the income eligibility requirement would prevent many people with HIV infection from having to impoverish themselves in order to qualify for basic health care services. At the same time it would relieve some of the reliance on public hospitals by the uninsured.

The Commission strongly believes these changes should be mandated; however, at the very least, states should be given the option of making these changes. In addition, the Commission believes these changes can and should lead to further changes that will include people with serious chronic conditions other than HIV disease.

3. **Medicaid payment rates for providers should be increased sufficiently to ensure adequate participation in the Medicaid program.** Unrealistically low reimbursement rates under the Medicaid program serve as a serious disincentive for health care providers to care for people who rely on Medicaid. Medicaid rates should be raised to Medicare levels.
4. **Congress and the Administration should work together to adequately raise the Medicaid cap on funds directed to the Commonwealth of Puerto Rico to ensure equal access to care and treatment.** Because of the existing cap on Medicaid funds allocated to the Commonwealth of Puerto Rico, none of the Medicaid recommendations the Commission has put forward to expand benefits for people with HIV disease would include individuals living in this part of the United States.
5. **States and/or the federal government should pay the COBRA premiums for low-income people with HIV disease who have left their jobs and cannot afford to pay the health insurance premium.**
6. **Social Security Disability Insurance (SSDI) beneficiaries who are disabled and have HIV disease or another serious chronic health condition should have the option of purchasing Medicare during the current two-year waiting period.** Medicaid should be required to purchase Medicare coverage for low-income SSDI beneficiaries.
7. **The federal government should fund the Ryan White CARE Act at the fully authorized level.**

8. **The following interim steps to improve access to expensive HIV-related drugs should be taken:**
  - (a) adequately reimburse for the purchase of drugs required in the prevention and treatment of HIV disease, including clotting factor for hemophilia;
  - (b) undertake, through the Department of Health and Human Services, a consolidated purchase and distribution of drugs used in the prevention and treatment of HIV disease;
  - (c) amend the Orphan Drug Act to set a maximum sales cap for covered drugs.

#### *Clinical Trials and Treatment-Related Research*

1. **Current efforts at the National Institutes of Health (NIH) to expand the recruitment of underrepresented populations in the AIDS Clinical Trials Group should be continued and increased.** While the Commission recognizes that lack of access to health care seriously hampers efforts to recruit underrepresented people into clinical trials, this does not mean it is impossible to do so. NIH has begun to increase participation and should aggressively pursue the participation of women and people of color in their clinical trials.
2. **The Secretary of Health and Human Services should direct the National Institutes of Health, the Health Care Financing Administration, and the Health Resources and Services Administration to work together to develop a series of recommendations to address the obstacles that keep many people from participating in HIV-related clinical trials, as well as the variables that force some people to seek participation in trials because they have no other health care options.**
3. **The Food and Drug Administration should aggressively pursue all options for permitting the early use of promising new therapies for conditions for which there is no standard therapy or for patients who have failed or are intolerant of standard therapy.**
4. **The National Institutes of Health should develop a formal mechanism for disseminating state-of-the-art treatment information in an expeditious and far-reaching manner.** While the Commission is aware of the efforts at NIH to disseminate information about state-of-the-art HIV treatment, the Commission is also aware that many health care providers are still not getting the information they need to responsibly care for their patients with HIV disease. The Commission believes NIH needs to develop a more formalized mechanism for disseminating information in a timely and ongoing fashion and should work with the federally funded AIDS Education and Training Centers, as well as professional medical societies, to reach as many people as possible.
5. **The Department of Health and Human Services should conduct a study to determine the policies of third-party payers regarding the payments of certain health service costs that are provided as part of an individual's participation in clinical trials conducted in the development of HIV-related drugs.**

### *Government Responsibilities*

1. **A comprehensive national HIV plan should be developed with the full participation of involved federal agencies and with input from national organizations representing various levels of government to identify priorities and resources necessary for preventing and treating HIV disease.** To develop the comprehensive national HIV plan, the Commission calls upon the President of the United States to designate an individual or lead agency with the authority and responsibility for instituting a cabinet-level process to articulate the federal component of an HIV plan, develop a mechanism for interagency as well as state and local participation and coordination, and establish a timeline for completion of key tasks.
2. **All levels of government should develop comprehensive HIV plans that establish priorities, ensure consistent and comprehensive policies, and allocate resources.** These plans should build on the national HIV plan and be developed at the state level with clear direction and support from each governor and at the appropriate local level (city or county) with clear direction and support from the appropriate locally elected official body. Each level of government should have an HIV Advisory Committee that is composed of representatives of diverse community-based organizations; the private sector; religious organizations; public safety officials; people living with AIDS; housing, health, and social service agencies; and other appropriate representatives.

The Commission recognizes that most states and many local governments may have an HIV plan. However, these existing plans should be carefully reviewed to ensure that they are up to date and comprehensive, and that they coordinate the entire spectrum of prevention and treatment services.

3. **Implementation of the Americans with Disabilities Act should be carefully monitored, and states and localities should evaluate the adequacy of existing state and local antidiscrimination laws and ordinances for people with disabilities, including people living with HIV disease.**
4. **Elected officials at all levels of government have the responsibility to be leaders in this time of health care crisis and should exercise leadership in the HIV epidemic based on sound science and informed public health practices.** The Commission recognizes that many issues raised by the HIV epidemic place pressures on elected officials to pass laws intended to respond to constituent fears and concerns. The Commission, however, is very concerned that policies may be enacted into law that are better left to scientists and public health experts. Legislative focus should be on full funding of HIV-related research, prevention, and treatment programs and on protecting those with HIV disease from discrimination.
5. **The federal government should develop an evaluation and technical assistance component for all federally funded HIV-related programs.** Understanding what works and why is essential to the development of effective prevention and care services for people living with HIV disease. It is essential that all HIV-related prevention and treatment efforts be evaluated and that the information be integrated into all planning, prevention, and health care delivery programs.

**Interim Report Number Six: The HIV/AIDS Epidemic in Puerto Rico  
(40 pp.) June 1992**

The Commission recommends:

1. That the issues confronted by the people of the Commonwealth of Puerto Rico be fully taken into consideration when establishing national policy and programs related to HIV infection and AIDS.
2. That the federal government and the Commonwealth of Puerto Rico urgently explore innovative approaches to partnerships, so that appropriate programs to respond to the HIV epidemic can be put in place with and for Puerto Ricans.
3. That Congress authorize the U.S. Department of Health and Human Services to conduct, in collaboration with the Commonwealth of Puerto Rico, a comprehensive study of the overall health status and services of people living in Puerto Rico. This study should also review the organization and delivery of health care in Puerto Rico and assess the federal role in assisting the people of Puerto Rico in addressing their most pressing health issues, particularly HIV disease. Consideration should also be given to including Puerto Rico in health surveys that cover the rest of the United States, such as NHANES, NMES, and NHIS, in such a manner that data on island residents can also be analyzed independently.
4. That efforts be made at all levels of government and the private sector to identify and address the impact of the HIV epidemic on the Puerto Rican communities in the United States. Pilot projects, including case management coordination, linking HIV efforts on the United States mainland with those in Puerto Rico, should be developed where migration patterns warrant.
5. That Congress and the Administration work together to raise the Medicaid cap on funds directed to the Commonwealth of Puerto Rico to ensure equal and adequate access to care and treatment.
6. That the U.S. Department of Health and Human Services, in collaboration with the government of the Commonwealth of Puerto Rico, seek ways to strengthen the technical, administrative, and coordinating capabilities of the Puerto Rico Department of Health. Similar support should also be provided directly to other health, social service, and housing agencies and community-based organizations in Puerto Rico. Technical assistance provided in these areas should be on-site and ongoing.
7. That approaches to expanding clinical research, as well as increasing access to experimental therapies (through clinical trials or expanded access programs) be explored by all involved in the HIV epidemic in Puerto Rico, including the federal, commonwealth, and municipal governments, as well as the private sector.
8. That special efforts be undertaken in Puerto Rico to educate the community and advocates for persons infected with HIV about the provisions of and rationale for anti-discrimination laws, such as the Americans with Disabilities Act, and to build adequate mechanisms to facilitate the enforcement of these laws. These efforts should be undertaken jointly by the federal government and the government of the Commonwealth of Puerto Rico. The Commonwealth government may wish to consider the possibility of establishing an HIV/AIDS anti-discrimination office similar to those found in cities such as Los Angeles and San Francisco.

9. That the Department of Anti-Addiction Services, the Puerto Rico Department of Health, nongovernmental organizations, and the federal government work together to create a strong, coordinated response to the twin epidemics of substance use and HIV. This response should include the expansion of treatment programs and establishment of bleach and clean needle/syringe programs.
10. That the Public Health Service, the Commonwealth of Puerto Rico, and community-based organizations continue, coordinate, and intensify existing prevention efforts. Additionally, these entities should develop ways to establish and expand prevention initiatives specifically targeted at adolescents; incarcerated populations; men who have sex with men; substance users; and women.

**Interim Report Number Seven: Housing and the HIV Epidemic  
(14 pp.) July 1992**

The Commission recommends:

1. That HUD make HIV/AIDS a top priority. The federal government must help support AIDS housing. The failure to do so contributes significantly to unnecessary human suffering and is costing the nation millions of dollars.
2. That Congress mandate that HUD recognize HIV/AIDS as a disability and not continue to deny people with HIV/AIDS access to housing funds targeted toward the disabled.
3. That people with HIV/AIDS be granted access to traditional housing programs. By the same token, Congress and HUD must adapt program requirements to meet the specific housing needs of people with HIV/AIDS.
4. That Congress make clear that HIV/AIDS-specific housing, under Shelter Plus Care and other federal programs, is both permitted and essential.
5. That Congress continue to play a leadership role in developing new funds to address the HIV/AIDS housing crisis.
6. That, as previously recommended by the Commission, the President of the United States name a lead official or agency to be responsible for a national plan to combat HIV/AIDS with cabinet-level, interagency coordination.
7. And finally, that at the local level a continuum of housing options be made available for people living with HIV disease that includes a range of alternatives, from hospice care and intermediate or supportive housing to rental subsidies that could allow people to reside independently until such time as they need additional care.

**Interim Report Number Eight: Preventing HIV Transmission in Health Care Settings (47 pp.) July 1992**

The central concern of the Commission continues to be ensuring patient safety. In all our deliberations, we have kept before us the central question: How can patients best be protected from possible infection with HIV or other bloodborne organisms? The scientific evidence, which is both extensive and persuasive, indicates that the following practices will best serve that purpose.

- There must be consistent, meticulous, and universal use of well-understood infection control procedures. Evidence developed from the study of another bloodborne infection, hepatitis B, which is at least one hundred times more infectious and probably ten times more common in health professionals, suggests that this must be the centerpiece of patient protection. The Commission believes no effort should be spared to make sure that all caregivers are trained in and apply proper infection control procedures in all health care settings, whether hospital, office, or home based.
- Operative or other invasive procedures in which injury to health care professionals occurs with any frequency should be eliminated or modified to the extent possible. Studies today suggest that most of the procedures now viewed as potentially hazardous could be changed or forgone. This will involve developing and testing new instruments and investigating new operative techniques. It may also entail rethinking the advisability of performing certain operations where the operating field cannot be readily visualized.
- All health care professionals should consider (based on behavioral or occupational exposure) the need to know their own HIV status. However, it is the Commission's belief that there is no current justification for restricting the practice of health care professionals on the basis of HIV status alone.

The Commission believes compliance with universal precautions and basic infection control practices should be aggressively pursued and carefully monitored in all health care settings. This includes private physicians' and dentists' offices and ambulatory surgery centers as well as hospitals, clinics, and clinical laboratories. It also includes private homes where health care is provided. Further research is necessary to substantiate further the types of universal precautions and alterations to professional techniques that best reduce the risk of all blood-to-blood exposure between workers and patients. Health care institutions must accept greater responsibility for training all caregivers, including family members, companions, and friends providing care at home, in proper infection control practices. Such institutions should also encourage alterations to professional techniques that might reduce risks of blood-to-blood exposure. In-service education should be supplemented with enhanced procedures for monitoring compliance with scientifically accepted infection control standards and proper professional techniques in all health care settings including clinics, offices, and homes.

The Commission believes infection control improvements are necessary to save lives. This is one area where there can be no cutting corners. There is no justification for allowing lapses in universal precautions and infection control procedures because of lack of necessary equipment, such as protective barrier clothing or convenient receptacles for the disposal of needles.

Monitoring and educational efforts related to implementation of the OSHA regulations deserve top priority. Moreover, new federal legislation should be considered to clarify and expand the employee groups reached by the regulations to include all of those at risk of occupational exposure to bloodborne pathogens.

The Commission encourages the continued monitoring of HIV and HBV transmission in order to understand the sources of risk and to refine risk estimates. Such studies can help to establish the knowledge base for the development of sound future policies. A limited number of carefully designed and controlled studies is preferable to engaging in look-back investigations each and every time a health care practitioner dies of HIV-related causes.



The Commission believes it is important to acknowledge fears concerning HIV transmission in the health care setting forthrightly and address them, without allowing them to overwhelm rational judgment. Policies must be directed at eliminating risks that are significant, rather than remote, speculative, or theoretical.

A much more concerted effort is needed to educate the public and health care providers about the risk of HIV and hepatitis B virus transmission and the most cost-effective ways to lower it. Leadership must be assumed at a number of levels. Health care professional schools are important settings for teaching about risks of disease transmission in the course of delivering care. An important aspect of medical, nursing, and allied health professional education is learning to respect universal precautions and infection control guidelines. These lessons must be imparted and reinforced regularly.

The Commission believes that strategies to reduce or eliminate the risk of HIV/HBV transmission must utilize the least restrictive alternatives; i.e., those promoting the greatest safety with the fewest adverse consequences for both patients and health care providers and preserving, insofar as possible, other social values.

Mandatory testing of health care workers in order to limit the practice of those who are HIV infected for infection control purposes is both misguided and unworkable in practice. Routine or mandatory testing of health care workers should not be a condition of employment or licensure. Nor should insurers require a negative HIV antibody test as a condition of malpractice coverage.

The Commission believes it is important to distinguish clearly between HIV antibody testing for clinical and/or behavioral purposes, on the one hand, and testing in order to secure results for infection control purposes, on the other. Individuals have a right to know if they are being tested for other than their own benefit.

The Commission believes that physicians and other health care workers may not ethically refuse to treat patients because of the patients' HIV infection. Patients' refusal to undergo HIV testing should not jeopardize receiving care.

The Commission believes that health care workers who limit or modify their range of professional activities because of HIV infection should be provided with opportunities to continue appropriate patient care activities. Professional associations and employers should be encouraged to promote the continued use of HIV-infected health care workers' skills and knowledge through career counseling and, where necessary, job retraining and placement. Adequate disability insurance should be available to those who suffer occupationally acquired HIV infection.

The Commission believes that a blanket policy of disclosure of health care providers' HIV status to patients would not only fail to make the health care workplace any safer, it would also have a deleterious impact on access to health care. Mandatory disclosure of a health care worker's HIV serostatus does little, if anything, to enhance the patients' safety. It inflates the risk of HIV transmission out of proportion to other risks and is inconsistent with the principles and practice of informed consent.

The Commission believes that physicians and other health care workers may not ethically avoid treating HIV-infected patients; it therefore encourages the development of insurance and other approaches designed to eliminate or minimize possible career or economic losses that might act as deterrents to providing care for HIV-infected patients.

The Commission feels strongly that measures adopted to prevent potential HIV transmission between health care workers and patients must be the least costly, least restrictive alternatives consistent with protection of the public health. Keeping these

objectives of cost reduction and minimal intrusiveness in mind is consistent with our society's deepest constitutional and legal traditions, while simultaneously respecting essential principles of public health and medical practice. The "cure" to the risk of HIV transmission in the health care workplace must not be more damaging to the public's health than the risk itself. In the Commission's view, federal, state, and local policymakers therefore must gauge carefully any unintended secondary and tertiary consequences of policies adopted in this area, to ensure that such policies do not create more difficulties than they solve. *Primum non nocere*—"first, do no harm"—even while acknowledging, frankly, that risks to public health in the HIV epidemic from transmission in the health care setting pale by comparison to the continued spread through unprotected sexual activity and risky drug use.

#### **Interim Report Number Nine: The Challenge of HIV/AIDS in Communities of Color (101 pp.) December 1992**

The National Commission on AIDS puts forward the following recommendations as a step toward focusing greater attention on the needs of communities of color and facilitating the increased availability of critical resources.

##### ***Race and Socioeconomics***

- Federal, state, and local governments should squarely confront problems associated with racial inequality and its effect on the public health. Public health officials should ensure that effective and equitable HIV policy, programs, and funding efforts are brought to bear in communities of color.
- Public health officials should work with researchers, health professionals, and community-based service providers to gain a better understanding of the role of cultural and socioeconomic factors in the transmission of HIV, the disease process, and access to care. Information gleaned from these efforts should be taken into account in designing HIV prevention messages, services, and programs, and in providing expanded treatment opportunities.

##### ***Prevention***

- The Centers for Disease Control and Prevention should review the adequacy of demographic information regarding HIV/AIDS currently available by race, ethnicity, and nationality, particularly with regard to Asian Americans/Pacific Islanders and Native Americans. Additionally, the National Center for Health Statistics should make information available regarding HIV/AIDS knowledge, attitudes, beliefs, and behaviors among Asian Americans/Pacific Islanders and Native Americans.
- The Centers for Disease Control and Prevention should ensure that the prevention and education needs of persons of color who engage in high-risk behaviors are appropriately addressed by current and future prevention initiatives and funding efforts. Programs specifically targeted toward men of color who have sex with other men, toward injection drug users, and toward women are needed.

- Federal, state, and local governments should join forces with the private sector in providing long-term support to community-based organizations serving communities of color. As part of this effort, the U.S. Public Health Service should expand and promote comprehensive and integrated programs for technical assistance to and capacity building in these communities.
- The President and the Congress should increase support for community-based primary care, including community health centers, migrant health centers, and clinics funded by the Indian Health Service to ensure delivery of prevention and care services, including those for HIV/AIDS.
- The President and the Congress should fully fund the Ryan White CARE Act and ensure that communities of color are adequately represented in the planning process and appropriately served by the resources available.
- The President and the Congress should provide additional incentives for health care professionals to work in underserved areas by increasing support for programs such as the National Health Service Corps and programs such as the Disadvantaged Minority Health Improvement Act of 1990 targeted specifically at increasing the number of minority health care professionals.
- Likewise, state and local jurisdictions should increase support for public hospitals and other locally supported components of comprehensive primary care systems that deliver HIV prevention and care services.
- Additionally, the Health Resources and Services Administration should assess the capacity of special initiatives, such as the Ryan White CARE Act and the Health Care for the Homeless Program, to develop and support a strong primary care infrastructure in communities of color.
- The federal government should provide adequate resources to community programs designed to improve access to health care and support services and to prevent the spread of HIV among adolescents. Passage of legislation similar to the proposed Comprehensive Services for Youth Act of 1992 would foster coordination and collaboration among educators, health care providers, and community-based organizations through the development and operation of citywide and statewide youth service center systems.
- The Agency for Health Care Policy and Research, the Health Resources and Services Administration, and the National Institute of Allergy and Infectious Diseases should conduct a review of current efforts to educate physicians on developments in HIV/AIDS care and aggressively pursue methods to improve the quality of HIV/AIDS care. In order to assure that people of color living with HIV receive the benefit of current developments in HIV/AIDS care these agencies should strive to coordinate better the dissemination of information, target physicians who practice in communities of color, and work intensively with schools and professional associations that have traditionally trained minority health professionals.

### *Clinical Trials*

The Commission believes there is an urgent need to improve the availability of primary care services in communities of color. To accomplish this a multifaceted approach is needed, including but not limited to the following efforts.

- The National Institutes of Health, in conjunction with other appropriate agencies within the Department of Health and Human Services, should intensify efforts to assure access to HIV/AIDS clinical trial information, with regard to trial opportunities, the results of research efforts, and their significance for clinical management. Emphasis should be placed on reaching populations that have had poor or underrepresentative access to clinical trial opportunities. Efforts should include the collection and dissemination of trial-related research and information on new developments in treatment. Dissemination should be carried out in a manner that ensures that information is current, accurate, and comprehensible to target populations and the health professionals who serve them.

#### ***Social Services***

- The federal government should work with the states to establish and support foster care programs for children with HIV infection and noninfected youth orphaned by the loss of parents to HIV/AIDS. Federal and state government should also support programs designed to assist family members in caring for children whose lives have been affected by HIV/AIDS.

In addition to the recommendations offered above, many of the recommendations set forth in previous reports and statements issued by the Commission are relevant to efforts to address the HIV/AIDS epidemic in communities of color. In particular, the Commission directs attention to the following reports and statements: *America Living with AIDS*, *HIV Disease in Correctional Facilities*, *The Twin Epidemics of Substance Use and HIV*, *The HIV/AIDS Epidemic in Puerto Rico*, *Housing and the HIV/AIDS Epidemic*, and *Resolution on U.S. Visa and Immigration Policy*.

#### **Interim Report Number Ten: Mobilizing America's Response to AIDS: Recommendations to President Clinton (6 pp.) January 1993**

1. The President should discuss the AIDS crisis with the American people.
2. The President should establish an AIDS Coordinator's Office reporting to the President.
3. The President should instruct the Secretary of HHS, in cooperation with the AIDS Coordinator and other Cabinet Secretaries as necessary, to immediately develop a National Strategic Plan to confront the epidemic. The plan should include:
  - a. Steps to implement a comprehensive, effective initiative for prevention of HIV infection that build on the knowledge already developed in many communities.
  - b. Steps to ensure access to health care and supportive services for those who are HIV infected.
  - c. Steps for education and legal action that will diminish unwarranted fears, stigmatization and discrimination against people with HIV infection.
  - d. Steps to ensure a broadly-based, better directed research approach to HIV/AIDS problems.
  - e. Steps to enhance U.S. involvement in the international response to HIV.
4. The President should request full funding for the Ryan White CARE Act.
5. The President should remove unwarranted restrictions relating to HIV infection.

6. The President should request a plan to make immediate treatment a reality for all drug users who seek it.

**Interim Report Number Eleven: HIV/AIDS: A Challenge for the Workplace**  
(26 pp.) June 1993

1. The President should emphasize the importance of addressing AIDS as a workplace issue by requesting initiation of an ongoing federal workplace AIDS program, which should include, with a timetable, the following:
  - a. Leadership, within their respective domains, by cabinet members and other senior administration officials.
  - b. New mechanisms for using the commitment of prominent business sector leaders to help guide the Administration's response to the challenges of AIDS in the workplace.
  - c. Convening of a national business and labor conference to focus on the impact of HIV/AIDS on the business sector.
  - d. Agency-specific workplace policies. As part of this effort, federal agencies should mandate the Office of Personnel Management guidelines, as originally suggested by the Presidential Commission in 1988. This recommendation has still not been implemented. Training of federal managers in workplace issues, notifying federal employees of their rights, and ensuring ongoing employee access to information and services should be priorities.
  - e. Ongoing employee education for the entire federal work force, at all levels, beginning with the White House staff.
  - f. Endorsement of CDC's Business Responds to AIDS program and utilization of its resources by federal and all other work sites throughout the nation.
  - g. Consideration of mechanisms for federal government contracts that assure that all contracted employers conduct HIV/AIDS education for their work force, and that these employers be alerted to the requirements of other federal, state, and local laws and regulations that address and protect the rights of HIV-infected employees in the workplace (similar to the requirements regarding "drug-free workplaces.")
  - h. Attention to ensuring that during the health care reform debate, all workplace health and education issues are given proper attention.
2. The Centers for Disease Control and Prevention should expand its support for the Business Responds to AIDS initiative by including efforts to obtain greater collaboration from existing mainstream organizations serving the business and

labor sectors, such as the U.S. Chamber of Commerce, the Business Roundtable, the Conference Board, and others, to promote the availability of this program to their members and to make AIDS far more visible as a business concern.

CDC should more actively strive to establish links between businesses and local or regional sources of technical assistance on workplace issues and education. The need for targeted support in particular industries should be assessed.

3. Federal agencies, particularly the Centers for Disease Control and Prevention, the Department of Justice, the Equal Employment Opportunity Commission, and the Department of Health and Human Services' Office of Civil Rights, should collaborate to provide increased support for continuing and strengthening the role played by AIDS service organizations and other community resources in providing assistance to businesses addressing AIDS workplace policies and education.
4. The Small Business Administration (SBA) should formalize and strengthen its preliminary investments in AIDS education efforts by designating an AIDS Coordinator for the agency. This individual would design and manage workplace AIDS education programs for all SBA employees and make these programs available to small businesses as part of SBA-sponsored conferences and seminars.
5. The Attorney General should underscore the commitment of the administration to enforcing the Americans with Disabilities Act and call upon states and employers to ensure full compliance with all aspects of the ADA dealing with HIV-infected employees, those perceived as having HIV, and those employees caring for people with HIV.

The Departments of Justice, Health and Human Services, and Labor, and the Equal Employment Opportunity Commission should intensify their efforts to educate employers on the requirements of the ADA, and provide technical assistance and training to employers on how to meet those requirements, especially as they pertain to reasonable accommodation for HIV-infected employees. The Department of Labor, as part of its role in administering unemployment insurance to state employment agencies and commissions, should also alert employers in the states to the requirements of federal, state, and local laws and regulations that address and protect the rights of HIV-infected employees in the workplace.

6. The Department of Labor should intensify its efforts to ensure that employers are knowledgeable about and comply with the provisions of the OSHA Bloodborne Pathogen Standard.

Employers should meet the standard's engineering controls, work practices, and personal protective equipment, employee education, and record keeping requirements, and rigorously monitor employee compliance with the requirements.
7. Congress, the Food and Drug Administration, and the Occupational Safety and Health Administration, after consultation with the Centers for Disease Control and Prevention, should take the steps necessary to reduce the risk of HIV transmission 1) for patients and workers in health care settings, and 2) for other

employees in occupations or situations where there is a risk of HIV transmission including:

- a. Congressional passage of legislation ensuring the application of the Occupational Safety and Health Act and OSHA regulations to all employees, irrespective of state of residence; and
  - b. FDA regulations designed to enhance the safety of devices used in health care settings.
8. **The Centers for Disease Control and Prevention should undertake a comprehensive program of research and development for infection control technologies and strategies to prevent occupational transmission of HIV and other bloodborne pathogens,** specifically including the safety performance evaluation of needle-bearing devices and other causes of percutaneous injuries to health care workers and sterilization and disinfection of reusable medical devices (as discussed in the Commission's previous report, *Preventing HIV Transmission in the Health Care Setting*.)

The foregoing discussions and recommendations focus on HIV/AIDS, as that is the Commission's specific mandate. However, much of what has been discussed in regard to the appropriate responses to employees with health problems and the opportunities for health promotion in the workplace are pertinent to other health problems. Opportunities to include initiatives on other health problems should be considered as the above recommendations are urgently implemented, with the ultimate goal of a comprehensive approach to health promotion in the workplace.

**Interim Report Number Twelve: Preventing HIV/AIDS in Adolescents  
(43 pp.) June 1993**

**1. *Presidential and Congressional Leadership is Essential to Prevention Education***

Neither previous administrations nor Congress has provided the vigorous and unequivocal leadership needed to address the controversy and confusion about HIV education. In fact, years of disagreement at the highest levels of the federal government over the proper messages to give young people have helped to create and perpetuate a national atmosphere of confusion and controversy. Controversy over and lack of consensus about how much and what kinds of information should be provided in schools continues to block effective action. A teacher living with AIDS, Marvin Jeter of Ohio, notes: "School-based HIV prevention efforts continue to be stalled by misunderstandings [and] politicizing about what prevention strategies are important and effective" (Jeter, 1993, p. 39). Dispute about the proper role of schools in addressing social problems, including HIV, and the capacity of schools to do so, hampers efforts to move forward with a prevention agenda.

The Commission reiterates its previous recommendations that the President should lead the American people to a new response to the HIV/AIDS epidemic, should appoint a National AIDS coordinator, and should call for the development

of a national strategic plan to confront the epidemic. The national strategic plan should contain plans for a national prevention initiative (National Commission on AIDS, 1991 and 1993) that includes steps for educating the public more thoroughly about AIDS and building community recognition of the need for more effective prevention efforts, including those directed at youth. Congress should place high priority on legislation directed towards comprehensive services for youth.

One component to the national prevention initiative should address the prevention of HIV infection in adolescents, particularly youth in high-risk situations. Comprehensive HIV prevention should include information, exploration of values and attitudes, skill building, and access to health care and social services, including condom availability. School-based prevention should be presented in an integrated, comprehensive health curriculum that includes discussion of sexuality and that teaches general prevention skills, while still providing HIV-specific information. Schools and other youth-serving institutions should select curricula and teaching strategies that have been tested for efficacy through research and/or evaluation. Programs should be developed with the involvement of parents and young people.

HIV prevention programs should be nonjudgmental in approach and structured from a public health perspective to help young people learn how to make healthy choices about sexuality. Such programs will be the most effective. The information provided to young people about sexuality and HIV should vary according to their age. Exhortations that adolescents perceive as unhelpful may only serve to distance youth, who may already be alienated, even further from the advice, care, and services they need and deserve. Prevention efforts limited to instilling fear or that omit important information will not be effective in facilitating healthy choices or sustained risk reduction.

Abstinence messages—such as the message to postpone sexual activity—should be included because this can be an effective way of reducing the risk of HIV. Those who choose abstinence require support. Information and skills building about other means of reducing the risk of HIV and other STDs, such as use of condoms, should be included. This potentially life-saving information is needed immediately by those who are sexually active and by all who may become so at some point later in their lives. Withholding such information leaves individuals vulnerable to HIV/STDs through ignorance.

## **2. *Promote Integrated Adolescent Programs***

Categorical funding constraints make it difficult to best serve young people. Schools and many other youth-serving institutions receive a mix of funds for a variety of programs designed to improve healthy growth and development (Wilhoit and Fraser, 1993). The difficulties presented by the inflexibility of categorical funding streams make it difficult for programs to provide comprehensive prevention programs. The inability to merge those funds to provide a comprehensive prevention program limits their effectiveness. The sheer number of sources from which an individual school or agency might receive funds can lead to overwhelming, time-consuming, duplicative paperwork. For example, the Klein Bottle Youth Programs, a community-based youth serving agency with an annual budget in excess of \$2.5 million, draws on



over 65 federal, state, county, and city funding sources to provide comprehensive services to youth in Santa Barbara, California (Coburn, 1993). Another example of the problems created by categorical funding is the current regulatory restriction on discussion of risky sexual behavior in Drug Free School programs, the largest federally supported prevention initiative, even though this is a hazardous potential consequence of drug use (Select Committee on Children, Youth and Families, 1992).

**Congress and Agencies should act to break down barriers to collaboration and co-location of services established by categorical funding constraints. This would allow schools and other youth-serving organizations to provide comprehensive disease prevention and health promotion programs to young people.**

3. ***Strengthen Staff Training***

There is a lack of training and capacity building for both teachers, other school staff, and other youth-serving professionals, including health care providers who are charged with providing HIV education treatment and services. While it is expensive to provide adequate, ongoing staff development, it is essential for the provision of adequate HIV prevention education. Pre- and inservice training and continuing education are all necessary.

The issues raised by HIV—including sexuality, alcohol and other drug use, sickness, and death—are emotionally charged topics that cannot be effectively addressed by unprepared instructors. **Congress should increase the level of federal resources for teacher training and other educational staff development in the sensitive areas raised in HIV education.** Preparation must address not only knowledge about HIV, but also help providers explore their own attitudes, which affect what and how they teach. It should also offer opportunities to practice and develop new teaching methods.

4. ***Enhance Health and Education Sector Collaboration***

The education community does not have ready access to much of the cutting-edge research on strategies for HIV prevention. The “transfer of technology” between the research community and schools needs strengthening. Teachers, school administrators, and school boards do not often read the technical journals in which research results are published, and, even if they do, researchers’ language is often difficult for nonexperts to understand (Wilhoit and Fraser, 1993).

**Federal health and education agencies should increase cooperation in order to facilitate “technology transfer” between the research and public health worlds and the education sector and to involve the education community in health promotion. Collaboration between state and local health agencies and education agencies should also be encouraged.**

Organizations that sponsor research and pilot projects should undertake and publish meta-analyses that identify the program design and implementation characteristics for prevention efforts that are predictors of effectiveness. Guidance for local action should be developed through collaboration between federal health and education agencies.

5. ***Address Youth Health Opportunities in Health Care Reform***

As the nation moves forward with both health care and education reform, important opportunities to address adolescent health needs emerge. Adequately providing for the health needs of young people presents special challenges because of the developmental, behavioral, and psychosocial aspects of adolescence. Providing appropriate care for this population presents a unique opportunity for prevention of disease and for the resulting future cost savings.

"School health" should be made a priority in the education sector. Within education reform, competency-based performance standards for health education, sexuality education, and HIV education should be set that will ask students to demonstrate mastery of a variety of health and prevention-related topics and tasks.

Health care and education reform should merge to create "healthy schools" that provide students with respect, adult mentoring, and critical thinking skills and that also work in partnership with the community to ensure students' access to health and other social services.

Within health care reform, adolescent health issues must be addressed. Incentives to encourage providers to make a commitment to adolescent health care should be considered. The Commission reiterates the importance of its previous recommendations in this regard, particularly those made in *America Living with AIDS* and *The Challenge of HIV/AIDS in Communities of Color*. Longer-term recommendations for universal health coverage and immediate needs, during the transition to a new system, should both be addressed.

6. ***Expand Research on Adolescent Health***

More research is needed to refine the knowledge base about adolescent sexual and other risk-taking behavior and to point the way toward effective HIV prevention strategies. Research, however, should not be funded at the expense of primary prevention programs.

A coordinated research agenda should be instituted that includes:

- a. A national survey on adolescent sexual behavior that will provide data not only on prevalence and demographics of sexual activities, but also on who and what has an impact on adolescent risk-taking behavior.
- b. Research on effective behavior change strategies and programs, including those that focus on youth in high-risk situations, and an assessment of how well the comprehensive approach to risk reduction works.
- c. New research that builds upon previously implemented comprehensive HIV programs for adolescents. Examples of such programs include the HIV Center for Clinical and Behavioral Studies (Rotherman-Borus, 1991), the Center for AIDS Prevention Studies at the University of San Francisco, programs for gay and bisexual youth (Remafedi, Farrow, and Deisher, 1991), and those programs implemented by the National Network of Hemophilia Treatment Centers and The National Hemophilia Foundation.

Additionally, a greater commitment of resources is needed for research including evaluation of interventions and for the dissemination of results from successful programs.

#### **7. Engage the Media in Health Promotion**

Messages conveyed by the entertainment and advertising media that glamorize sexuality or drug and alcohol use and ignore the consequences of unprotected intercourse or substance abuse feed adolescent denial of the threat of HIV/AIDS and other potential consequences.

The federal government should work with the entertainment industry and other media (for example, the advertising industry) to develop strategies for conveying positive messages on HIV/STD and drug-use risk reduction to adolescents.

#### **Interim Report Number Thirteen: Behavioral and Social Sciences and the HIV/AIDS Epidemic. July 1993**

Note: at the time *AIDS: An Expanding Tragedy* went to press, recommendations for this report were not yet finalized.

#### **Final Report: AIDS: An Expanding Tragedy (142 pp.) June 1993**

##### **Recommendation 1**

**Leaders at all levels must speak out about AIDS to their constituencies.**

Our President must speak out clearly and forcibly about the nature, extent, and needs of the AIDS disaster. This has been our foremost recommendation since 1991. One AIDS activist group has as its symbol a pink triangle with the phrase, "silence=death." There is much to suggest that they are right. The appalling lack of frank discussion about the epidemic at all levels of national leadership fostered a woefully inadequate response, yielding death and suffering well in excess of what might have been. Silence has existed at too many levels of responsibility. Few governors, mayors, members of Congress, corporate executives, community or religious leaders, have stepped forward—perhaps taking their cue from previous Presidents. Consequently, the scale of the problem is seriously underestimated, and fear, prejudice, and misinformation abound. Leaders have both the capacity and the responsibility to coalesce their communities to find solutions.

We are vividly aware of the fact that addressing AIDS—and particularly issues that require discussing sexuality or drug use—is difficult for many to deal with comfortably. Further, some of the steps that will be required to address the epidemic better will be unpleasant or unpopular in the minds of many. But to confront difficult and sensitive issues is what true leadership means and requires. It would, in our judgment, make a profound difference in our national response to HIV disease if full and frank discussion of all its implications was initiated and encouraged by those in positions of responsibility at all levels.

##### **Recommendation 2**

**We must develop a clear, well-articulated national plan for confronting AIDS.**

Again, high on our list of recommendations, and that of the Presidential Commission preceding us, has been the development of a carefully crafted national strategic plan to address the issues of prevention, care, and research, required to deal with the HIV epidemic.

To this end, we have suggested such a plan directly to the President in our report, *Mobilizing America's Response to AIDS*. We have spelled out the authority and resources necessary for the coordinating office required to deal with the numerous cabinet departments that must be involved in such planning. Along similar lines, we have pointed to the singular absence of a national prevention strategy worthy of the name. We have also indicated the need for more overall planning for HIV-related research, housed appropriately within the National Institutes of Health, and the desperate need for a compassionate continuum of care for those infected. The obvious reasons for having such overarching plans, still absent in the twelfth year of the epidemic, need little further comment, except perhaps that the underlying theme of the plans should be to address sexual and drug-use behavior from a public health perspective.

All of our other recommendations, past or present, follow logically from the above. There is a compelling need for a functioning public health system with the ability to conduct appropriate prevention programs, free from censorship, that would serve the special needs of gay men, of lesbians, of communities of color, of those who use drugs, of women, of children, and of adolescents. The need for better therapeutic agents, long-term care, housing, social support services, and their financing—all must be embodied in those plans. Our reports to date, and most particularly *America Living with AIDS*, spell out the particulars. Clearly our work is unfinished. Although the Commission has listened diligently, considered carefully, and kept the problem of AIDS before the public, most of our recommendations remain to be implemented. But it is time for AIDS to be swept into the mainstream of America's national agenda. To continue to treat HIV/AIDS as a marginal problem gravely threatens our nation's future. Without action on our nation's unfinished business on AIDS, we will have a continually expanding tragedy. We call on America to get on with the job. What should be done is not complicated. But it requires leadership, a plan, and the national resolve to implement it.

## APPENDIX D: Commission Chronology, 1989-1993

### 1989

August 3	Meeting to select Chairman and discuss future direction of Commission. Washington, D.C.
August 17	Meeting to select Executive Director. Washington, D.C.
September 6	Statement in support of passage of the Americans with Disabilities Act.
September 18	Hearings to gain an overview of the HIV epidemic and Commission meeting to review the recommendations made by the Presidential Committee on the Human Immunodeficiency Virus Epidemic. Washington, D.C.
September 19	Site visit to the Whitman Walker Clinic, meeting with General Services Administration General Counsel, and meeting to discuss Commission business. Washington, D.C.
September 19	Statement in support of increase in AIDS funding in the FY 1990 Appropriations Bill.
September 26	Statement in support of the goal of treatment on demand for drug users.
November 2-3	Hearings on health care, treatment, finance, and international aspects of the HIV epidemic. Washington, D.C.
November 3-4	Commission meeting on future direction. Leesburg, Virginia.
November 7	Statement in support of continued funding of research on the effectiveness of bleach distribution.
December 5	First interim report to President Bush and the Congress: "Failure of U.S. Health Care System to Deal with HIV Epidemic."

**1989 continued**

December 12      Press conference in which a Commission resolution calls for an end to discriminatory visa and immigration practices and a review of immigration policies regarding communicable diseases, particularly HIV infection. Washington, D.C.

**1990**

January 4-5      Hearing of the Working Group on Federal, State, and Local Responsibilities. The hearing's purpose was to examine the roles and responsibilities of different levels of government in responding to the AIDS/HIV epidemic. St. Paul, Minnesota.

January 24-26      Hearing and site visits to assess regional aspects of the HIV epidemic in Southern California. Visits were made to Los Angeles Area community-based organizations, clinics, a hospice, and a public hospital. Hollywood, California.

February 15-16      Hearing of the Working Group on Social and Human Issues to examine the relationship of early intervention, HIV testing, and psychosocial issues to HIV. Boston, Massachusetts.

February 26-27      Site visits to study issues of HIV and AIDS among the homeless, drug users, and hemophiliacs. New York City, Newark, and Jersey City.

February 28      Testimony of Chairman June E. Osborn, M.D., before the Senate Appropriations Committee.

March 6      Testimony of Chairman June E. Osborn, M.D., on meeting the health care needs of people living with HIV and AIDS before the Task Force on Human Resources of the Committee of the Budget of the United States House of Representatives.

March 6      Endorsement of principles and objectives of the Comprehensive AIDS Resources Emergency (CARE) Act of 1990.

March 9      Letter to President Bush urging him to resolve visa controversy before international conferences to be held in the United States in June and August of 1990.

March 15      Statement that, despite debate among epidemiologists, the HIV epidemic will have a greater impact in the 1990s than in the 1980s.

**1990 continued**

- March 15 Summary report of the Working Group on Federal, State, and Local Responsibilities, including recommendations from January meeting in St. Paul, Minnesota, on the roles and responsibilities of different levels of government.
- March 15 Hearings to review executive and legislative branch initiatives, including the National Drug Control Strategy and the Report of the U.S. Bipartisan Commission on Comprehensive Health Care. Washington, D.C.
- March 16 Commission meeting to discuss future business activities. Washington, D.C.
- April 13 Testimony of Chairman June E. Osborn, M.D., before the House Appropriations Committee.
- April 16-17 Site visits to examine issues surrounding AIDS in rural communities. Waycross, Albany, and Macon, Georgia.
- April 24 Second interim report to President Bush and the Congress: "Leadership, Legislation, and Regulation."
- May 7 Letters to Senate Majority Leader Mitchell and Senate Minority Leader Dole urging Senate consideration of the Ryan White CARE Act of 1990.
- May 7-8 Hearing to review current research activities, particularly clinical trials, and Commission meeting. Washington, D.C.
- May 11 Statement endorsing principles and objectives of AIDS Prevention Act (H.R. 4470) and Medicaid AIDS and HIV Amendments Act of 1990 (H.R. 4080).
- May 24 Letters to Senators Kennedy and Hatch underscoring support for the Americans with Disabilities Act and declaring the amendment concerning food handlers bad public health policy.
- June 6 Letters to Speaker of the House Foley and House Minority Leader Michel urging Congress to resist attempts to impose a federal mandate on states for name reporting.
- June 27 Testimony of Commissioner Donald S. Goldman before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce of the United States House of

**1990 continued**

Representatives regarding immigration and visa policies and the Rowland Bill (H.R. 4506).

July 9-10

Hearing by the Working Group on Social and Human Issues to examine early intervention and HIV testing from the public health perspective, as well as the range of social and human services needed by people affected by the HIV/AIDS epidemic. Dallas, Texas.

July 17

Commission meeting to discuss activities for FY 1991. Washington, D.C.

July 18-19

Hearings to review current health care personnel and work force issues. Washington, D.C.

July 30-31

Working Group on Social and Human Issues hearing and site visits to examine the range of services needed by people affected by the HIV/AIDS epidemic, the partnerships and coalitions necessary to provide these services, and the social and human services programs established in the Seattle-King County Region. Seattle, Washington.

August

First annual report to the President and the Congress documenting and describing the work of the Commission over the preceding year.

August 16-17

Hearings and site visits to examine HIV infection and AIDS in correctional facilities. New York State.

August 21

Third interim report to President Bush and the Congress: "Research, the Work Force, and the HIV Epidemic in Rural America."

August 22-23

Hispanic Think Tank AIDS Forum II on AIDS in Puerto Rico and among the Puerto Rican population on the mainland. San Juan, Puerto Rico.

September 17-18

Hearings to discuss issues of public health and the HIV epidemic. Washington, D.C.

September 18

Letter to President Bush and the Congress calling for full funding of the Ryan White CARE Act.

November 27-28

Hearings and site visits to assess the impact of the HIV epidemic in the Commonwealth of Puerto Rico. San Juan, Puerto Rico.



**1990 continued**

- December 17      Hearings on HIV disease in African American communities. Baltimore, Maryland.
- December 18      Technical briefing on health care financing issues and Commission business meeting. Baltimore, Maryland.

**1991**

- January 16      Commission meeting to discuss future activities. Washington, D.C.
- January 17      Hearing on HIV disease and substance use. Washington, D.C.
- February 6-7      Site visits to examine regional response to the HIV epidemic. Belle Glade and Miami, Florida.
- February 15      Letter to Charles McCance, Director of Quarantine, Centers for Disease Control, regarding the immigration issue.
- February 25-28      Site visits to study HIV disease in Native American communities. Oklahoma, Minnesota, South Dakota, Arizona, and New Mexico.
- March 11-13      Hearings and site visits to assess pediatric and adolescent HIV disease and issues surrounding HIV/AIDS in Hispanic communities. Chicago, Illinois.
- March 15      Fourth interim report to President Bush and the Congress: "HIV Disease in Correctional Facilities."
- March 21      Testimony of Chairman June E. Osborn, M.D., before the Senate Appropriations Committee.
- April      Report of the Working Group on Social and Human Issues.
- April 22-23      Commission meeting on financing, the federal structure, and consultants' reports for the second annual Commission report. Washington, D.C.
- April 30      Testimony of Chairman June E. Osborn, M.D., before the House Appropriations Committee.

**1991 continued**

May 16-17	Hearings on the HIV epidemic in the lesbian, gay, and bisexual communities and on HIV disease among Asians, Asian Americans, and Pacific Islanders. San Francisco, California.
May 18	Commission meeting to discuss scientific and regulatory aspects of HIV-related research and drug development. San Francisco, California.
June 5	Letter to Members of Congress regarding funding of the Ryan White CARE Act.
June 5-7	Hearings on women and HIV disease, civil rights and HIV disease, and Commission meeting on the second annual Commission report. Denver, Colorado.
June 10-11	Meeting to discuss the second annual Commission report. Alexandria, Virginia.
June 13	Letter to Attorney General Richard Thornburgh with accompanying letter to Secretary of Health and Human Services Louis Sullivan regarding current immigration policy.
June 23-24	Working Group meeting to discuss activities for FY 1992. Arlie, Virginia.
July 10-11	Commission meeting to discuss activities for FY 1992. Alexandria, Virginia.
July 11	Statement of the Commission's stand on HIV testing in the health care workplace.
July 11	Statement of the Commission's stand on immigration.
July 24	Letter to congressional leadership regarding support for funding of behavioral and social research.
August 1	Letter to President Bush from Commissioner Belinda Mason requesting immediate action.
August 6	Fifth interim report to President Bush and the Congress: "The Twin Epidemics of Substance Use and HIV."
August 7-8	Commission meeting to review "America Living with AIDS" and FY 1992 activities. Alexandria, Virginia.

**1991 continued**

August 26	Working Group meeting to identify the current issues and concerns of religious communities responding to the HIV/AIDS epidemic, and to discuss the interface between the religious communities' response and the federal government's response to the HIV/AIDS epidemic. Washington, D.C.
September 19	Testimony of Vice Chairman David E. Rogers, M.D., before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives.
September 25	Second annual report to the President and the Congress: "America Living With AIDS." Letter to President Bush.
October 17	Testimony of Chairman June E. Osborn, M.D., before the Select Committee on Narcotics Abuse and Control, U.S. House of Representatives.
October 25	Commission names new Executive Director, Roy Widdus, Ph.D.
November 5	Hearing on various proposals to reduce the risk of transmission of bloodborne pathogens, including HIV, in the health care setting, particularly focusing on social and economic implications of risk-reduction proposals and their potential impact on access to health care services. Washington, D.C.
November 6	Commission meeting to discuss the workplan for FY 1992. Washington, D.C.
December 9	Commission meeting with President Bush. Washington, D.C.
December 9-10	Hearings on the impact and ramifications of the CDC's proposed revised classification system for HIV infection and expanded AIDS surveillance case definition for adolescents and adults. Washington, D.C.
December 12	Letter to Assistant Secretary of Health and Human Services James Mason.
December 12	Letter to William L. Roper, Director of the Centers for Disease Control, on policy implications of HIV disease definitions.
December 12	Letter to President Bush on the national response to the HIV epidemic.

1992

January 14	Hearing on the future of the HIV epidemic and Commission meeting. Washington, D.C.
February 19-20	Commission business meeting. Washington, D.C.
February 21	Letter to Susan Parker, Associate Commissioner for Disability, Social Security Administration.
March 2-3	Hearings to examine housing issues and the HIV epidemic, as well as site visits within the Boston area. Boston, Massachusetts.
April 9	Testimony of Chairman June Osborn, M.D., before the Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. House of Representatives.
April 23	Brief of <i>Amicus Curiae</i> by named members of the National Commission on AIDS. <i>Haitian Centers Council, Inc. et al., v. Gene McNary, Commissioner, Immigration and Naturalization Service, et al.</i> , No. 92-6090 (2d Cir.).
May 18-19	Hearings on sex, society, and the HIV epidemic, as well as site visits within the New Orleans area. New Orleans, Louisiana.
June 2	Sixth interim report to the President and the Congress: "The HIV/AIDS Epidemic in Puerto Rico." San Juan, Puerto Rico.
June 15-16	Hearings on communication and the HIV epidemic and Commission meeting. Kansas City, Kansas, and Kansas City, Missouri.
July 17	Letter to Kenneth W. Starr, Solicitor General of the United States, Department of Justice, urging action on <i>Greenberg v. H &amp; H Music Company</i> , No. 91-1283, on petition for a writ of certiorari, to ensure health care insurance for those with disabling diseases, including HIV.
June 24	Commission meeting with Secretary of Health and Human Services Louis Sullivan.
June 25	Release of statement on the meeting between the National Commission on AIDS and the Secretary of Health and Human Services.

**1992 continued**

- July Seventh interim report to the President and the Congress: "Housing and the HIV/AIDS Epidemic, Recommendations for Action."
- July 27 Letter of support for Comprehensive Services for Youth Act of 1992.
- July Eighth interim report to the President and the Congress: "Preventing HIV Transmission in Health Care Settings."
- July 30 Letters to state health directors in support of the report "Preventing Transmission of HIV/AIDS in Health Care Settings."
- September 14 Commission meeting to discuss Commission activities for FY 1993. Washington, D.C.
- October 19 Meeting of Commission subgroup and NAPO/HHS on proposed regulations on interim methadone treatment. Washington, D.C.
- November 2 Statement by Vice Chairman David E. Rogers, M.D., on the resignation of Magic Johnson from the NBA.
- November 17 Hearing on leadership of national response and on mobilizing the federal government, and recommendations to the President and Congressional leadership on actions in special areas that the executive and legislative branches should take in early 1993 to enhance the response to the HIV/AIDS epidemic. Washington, D.C.
- November 18 Commission meeting to discuss Commission activities for the remainder of FY 1993. Washington, D.C.
- December 14 Testimony before Subcommittee on Health for Families and the Uninsured, Committee on Finance, U.S. Senate.

**1993**

- January 11 Ninth interim report to the President and the Congress: "The Challenge of HIV/AIDS in Communities of Color," and Commission business meeting.
- January 22 Tenth interim report to the President and the Congress: "Mobilizing America's Response to AIDS."

**1993 continued**

January 28	Statement on strengthening the NIH Office of AIDS Research.
February 11	Statement on immigration policy.
February 12	Commission meeting to discuss Commission activities for the remainder of FY 1993.
February 17	Letter to President Clinton urging airlift of HIV-infected Haitians on Guantanamo Bay Naval Base for medical care and immigration hearing.
March 10-11	Hearings on behavioral research and AIDS prevention, HIV/AIDS and the workplace, school-based prevention programs, and youth initiative programs. Austin, Texas.
March 25	Letters to Congressional leaders urging legislative action with regard to ERISA, to ensure that all persons with chronic diseases and disabilities, including HIV, will not face limitation or elimination of health insurance benefits when they become sick.
March 25	Letters to Congressional leaders supporting the additional funds for programs under Ryan White CARE Act, included in the FY 1993 Supplemental Appropriations Bill.
March 25	Statement on GAO needle-sharing report.
April 22	Letters to Appropriations Committees in support of President Clinton's FY 1994 budget request for HIV/AIDS programs.
April 28	Commission meeting to discuss final report.
June 2	Eleventh interim report to the President and the Congress: "HIV/AIDS: A Challenge for the Workplace."
June 2	Twelfth interim report to the President and the Congress: "Preventing HIV/AIDS in Adolescents."
July	Thirteenth interim report to the President and Congress: "Behavioral and Social Sciences and the HIV/AIDS Epidemic."
June 28	Final report to the President and the Congress: "AIDS: An Expanding Tragedy."
September 3	Commission ceases operations.

## **APPENDIX E: List of Witnesses Participating in Commission Hearings**

**Overview of the HIV Epidemic  
Washington, DC  
September 18, 1989**

### ***Overview***

Mathilde Krim, Ph.D., American Foundation for AIDS Research, New York, NY

### ***People Living with AIDS Panel***

William Bettelyoun

Dave Johnson

Lou Katoff, Ph.D.

Belinda Mason, Commissioner, National Commission on AIDS

James R. Allen, M.D., Director, National AIDS Program Office, Department of Health  
and Human Services, Washington, DC

Chai R. Feldblum, Co-Chair, Civil Rights Task Force, National Organization Responding  
to AIDS, Legislative Counsel for the American Civil Liberties Union,  
Washington, DC

C. Everett Koop, M.D., Former U.S. Surgeon General, Maryland

Jean McGuire, Director, AIDS Action Council, Chair, National Organization Responding  
to AIDS, Boston, MA

Robert G. Newman, M.D., President, Beth Israel Medical Center, New York, NY

**Health Care, Treatment, and Finance Aspects of the HIV Epidemic  
Washington, DC  
November 2, 1989**

Dennis P. Andrulis, M.P.H., Ph.D., President, National Association of Public Hospitals,  
National Public Health and Hospital Institute, Washington, DC

Elizabeth Barton, M.P.S., Samaritan Village, Inc., New York, NY

Peter Brandon Bayer, J.D., LL.M., M.A., Hemophiliac with HIV Infection,  
Baltimore, MD

Charles J. Carman, President, World Federation of Hemophilia, Montreal, Canada

Deborah Cotton, M.D., M.P.H., Clinical Director for AIDS, Beth Israel Hospital,  
Boston, MA

Nancy Neveloff Dubler, LL.B., Director, Division of Legal and Ethical Issues in Health Care, Department of Epidemiology and Social Medicine, Montefiore Hospital and Medical Center, Bronx, NY  
 Theodore M. Hammett, Ph.D., Abt Associates, Inc., Cambridge, MA  
 Ralph Hernandez, Person Living with AIDS  
 Craig Kessler, M.D., George Washington University Hospital, Washington, DC, National Hemophilia Foundation, New York, NY  
 Jonathan M. Mann, M.D., M.P.H., World Health Organization, Geneva, Switzerland  
 James M. Oleske, M.D., Division for Allergy, Immunology and Infectious Diseases, Department of Pediatrics and Preventive Medicine, University of Medicine and Dentistry of New Jersey, Newark, NJ  
 Mark D. Smith, M.D., Associate Director, AIDS Services, Johns Hopkins University School of Medicine, Baltimore, MD  
 James C. Welch, R.N., AIDS Program Office, Division of Public Health, State of Delaware, Wilmington, DE  
 Catherine Wilfert, M.D., Duke University School of Medicine, Durham, NC

**International Aspects of the HIV Epidemic  
 Washington, DC  
 November 3, 1989**

Peter S. Arno, Ph.D., Department of Epidemiology and Social Medicine, Montefiore Medical Center, Bronx, NY  
 Mary Ann Bailey, Ph.D., Adjunct Associate Professor of Economics and Health Care Science, George Washington University, Washington, DC  
 Jesse Green, Ph.D., Director, Department of Health Policy Research, New York University Medical Center, New York, NY  
 John S. Holloman, Jr., M.D., William F. Ryan Community Health Center, New York, NY, National Association of Community Health Centers, Washington, DC  
 Robert F. Hummel, Assistant Commissioner, New Jersey State Department of Health, Division of AIDS Prevention and Control, Trenton, NJ  
 Paul Jellinek, Ph.D., Vice President, Robert Wood Johnson Foundation, Princeton, NJ  
 Si-Hoi Lam, M.D., Hill Health Center, New Haven, CT  
 Philip R. Lee, M.D., Director, Institute of Health Policy Studies, University of California School of Medicine, San Francisco, CA  
 Samuel C. Matheny, M.D., M.P.H., Deputy Director, AIDS Services, Health Resources and Services Administration, Rockville, MD  
 Anne A. Scitovsky, M.A., Health Economics Division, Palo Alto Medical Foundation/Research Institute, Palo Alto, CA

***Hispanic/Latino Teleconference***

Eunice Diaz, M.S., Commissioner, National Commission on AIDS  
 Patricia Mendoza, Continuing Education Division, University of California, Los Angeles, CA



**Working Group on Federal, State, and Local Responsibilities**  
**St. Paul, MN**  
**January 4-5, 1990**

Diane Ahrens, Commissioner, National Commission on AIDS  
James R. Allen, M.D., Director, National AIDS Program Office, Department of Health and Human Services, Washington, DC  
Sister Mary Madonna Ashton, Commissioner, Minnesota Department of Health, Minneapolis, MN  
State Senator Linda Berglin, National Conference of State Legislatures, Washington, DC  
James T. Bulger, Deputy Director, Governmental Relations and Strategic Planning, New York State AIDS Institute, New York Department of Health, New York, NY  
Councilmember Brian Coyle, National League of Cities, Washington, DC  
Patricia E. Franks, Coordinator, AIDS Resource Programs, Institute of Health Policy Studies, University of California, San Francisco, CA  
Honorable Donald Fraser, Mayor of Minneapolis, MN, U.S. Conference of Mayors, Washington, DC  
Richard Johnson, Staff member, U.S. Conference of Mayors, Washington, DC  
A. Billy S. Jones, Director, Minority Affairs, National AIDS Network, Washington, DC  
Ann Klinger, National Association of Counties, Washington, DC  
Charles Konigsberg, M.D., M.P.H., Commissioner, National Commission on AIDS  
David Lurie, Commissioner of Health, Minneapolis, MN  
Councilmember Angel L. Ortiz, Philadelphia City Council, Philadelphia, PA  
Councilmember Lori Palmer, Dallas City Council, Dallas, TX  
James E. Smith, National Association of People with AIDS, Washington, DC  
G. Herbert Stout, County Commissioner, Raleigh, NC  
Timothy R. Wolfred, Psy.D., Mayor's HIV Task Force, San Francisco, CA

**Regional Aspects of the HIV Epidemic in Los Angeles, CA**  
**Hollywood, CA**  
**January 25, 1990**

Bisher Akil, M.D., Assistant Professor of Medicine, Kenneth Norris Hospital, Los Angeles, CA  
Henry Alonzo, AIDS Outreach Coordinator, El Centro Human Services Corporation, Los Angeles, CA  
Pam Anderson, AIDS Project Los Angeles, CA  
Xylina D. Bean, M.D., King/Drew Medical Center, Los Angeles, CA  
Honorable Tom Bradley, Mayor, City of Los Angeles, CA  
Michael Cousineau, Dr.P.H., Los Angeles Homeless Health Care Project, Los Angeles, CA  
Senator Alan Cranston, CA (not present, excerpts read from his letter addressed to the Commission)

Viviane Doche-Boulos, Ph.D., Southern California Association of Governments,  
Los Angeles, CA

Supervisor Edmund D. Edelman, Board of Supervisors, County of Los Angeles, CA

William Edelman, L.C.S.W., A.C.S.W., Manager, Orange County Drug Abuse Services,  
Santa Ana, CA

Martin Finn, M.D., Medical Director, Los Angeles County Department of Health  
Services, Los Angeles, CA

Dale Fleishman, Contract Manager/Analyst, Office of AIDS Coordination, San Diego  
County Department of Health Services, San Diego, CA

J. Craig Fong, J.D., Director, Downtown Legalization Project, Asian/Pacific Legal Center  
of Southern California, Los Angeles, CA

Robert Gates, M.P.A., Los Angeles County Department of Health, Los Angeles, CA

Gil Gerald, Executive Director, Minority AIDS Project, Los Angeles, CA

Dean Goishi, Project Director, Asian/Pacific Lesbians and Gays, Los Angeles, CA

Jackie Goldberg, M.A.T., President, Los Angeles Board of Education,  
Los Angeles, CA

Sharon Grigsby, M.B.A., President, Visiting Nurses Association, Los Angeles, CA

Donald G. Hagan, M.D., AIDS Services Foundation, Orange County, Santa Ana, CA

Bessie Hughes, R.N., Assistant Nursing Director, King/Drew Medical Center,  
Los Angeles, CA

Danny Jenkins, Director of AIDS Education, Tarzana Treatment Center, Tarzana, CA

David Johnson, City of Los Angeles AIDS Coordinator, Community Development  
Department, Human Services Section, Los Angeles, CA

Wilbert Jordan, M.D., M.P.H., Director, Office of Graduate Medical Education, King/  
Drew Medical Center, Los Angeles, CA

Gabe Kruks, Director of Youth Services, Gay and Lesbian Community Service Center,  
Los Angeles, CA

Juan Ledesma, Case Manager, AIDS Project Los Angeles, CA

Raul Magaña, Ph.D., Project Supervisor, AIDS Community Education, Orange County  
Health Care Agency, Santa Ana, CA

Connie Norman, AIDS Coalition to Unleash Power, Los Angeles, CA

Lydia Otero, Gay and Lesbian Latinos Unidos, Los Angeles, CA

Tom Prendergast, M.D., M.P.H., Division Manager, Epidemiology, Orange County  
Health Care Agency, CA (not present)

Paul Rothman, D.O., Pacific Oaks Medical Group, Sherman Oaks, CA

Honorable Rand Schrader, Chair, Los Angeles AIDS Commission, Los Angeles, CA

Dexter Shaw, Minority AIDS Project, Los Angeles, CA

Ruth Slaughter, Community Coordinator, Women and AIDS Risk Network (WARN),  
Los Angeles, CA

Mario Solis-Marich, Neighborhood AIDS Consortium, Los Angeles, CA

Irma Stranz, Ph.D., Director, Drug Abuse Program Office, Los Angeles County Drug  
Abuse Program Office, CA

Alex Taylor, M.P.H., Public Health Program Manager, San Bernardino County AIDS/  
STD Program, San Bernardino, CA

Michael Weinstein, President, AIDS Hospice Foundation, Los Angeles, CA

Penny Weismuller, Dr.P.H., AIDS Coordinator, Orange County Health Care Agency,  
Santa Ana, CA

Fred Wietersen, President, Being Alive, Los Angeles, CA  
Phill Wilson, Co-Chairperson, Black Gay and Lesbian Leadership Forum,  
Hollywood, CA

**Working Group on Social and Human Issues  
Boston, MA  
February 15-16, 1990**

***Facilitator***

Marc J. Roberts, Ph.D., Professor, Harvard University, Cambridge, MA

Rona N. Affoumado, Executive Director, Community Health Project, New York, NY  
Hortensia Amaro, Ph.D., Assistant Professor, School of Public Health, Boston  
University, Boston, MA

Walter F. Batchelor, Director of Research, John Snow, Inc., Research and Training  
Institute, Member of American Psychological Association, Washington, DC

Kate Cauley, Ph.D., Deputy Director, AIDS Policy Project, Intergovernmental Health  
Policy Project, Washington, DC

Paul Cleary, M.D., Associate Professor of Medical Sociology, Harvard School of Public  
Health, Cambridge, MA

Deborah Cotton, M.D., M.P.H., Clinical Director for AIDS, Beth Israel Hospital,  
Boston, MA

Mindy Domb, AIDS/HIV Educator, Pittsfield, MA

Eric L. Engstrom, Executive Director, National AIDS Network, Washington, DC

William F. Flanagan, Director of Public Policy, American Foundation for AIDS  
Research, New York, NY

Marshall Forstein, M.D., Outpatient Psychiatry, Cambridge Hospital, Cambridge, MA

Jackie Gelfand, M.A., M.F.C.C., ATS Project Manager, Los Angeles Gay and Lesbian  
Community Services Center, Los Angeles, CA

Alan Hinman, M.D., M.P.H., Director, Center for Prevention Services, Centers for  
Disease Control, Atlanta, GA

Wayne Johnson, Jr., M.S.P.H., School of Public Health, University of South Carolina,  
Columbia, SC

Jeff Levi, Consultant, Washington, DC

Harvey J. Makadon, M.D., Executive Director, Boston AIDS Consortium, Assistant  
Professor, Harvard Medical School, Cambridge, MA

John F. Mazzuchi, Ph.D., Office of Assistant Secretary for Health Affairs, Department of  
Defense, Washington, DC

Jim McEvoy, National Association of People with AIDS, Washington, DC

Alvin Novick, M.D., Professor of Biology, Yale University; Mayor's Task Force on  
AIDS, New Haven, CT

Joseph O'Neill, M.D., M.P.H., Chief Medical Director, Division of HIV Services, Health  
Resources and Services Administration, Rockville, MD

Alonzo Plough, Ph.D., Deputy Commissioner for Public Health, Boston, MA

Romeo Sanchez, Human Rights Specialist, New York City Commission on Human  
Rights, New York, NY

H. Denman Scott, M.D., Director of Health, Rhode Island Department of Health,  
President, Association of State and Territorial Health Officials, Washington, DC  
Peter Smith, M.D., Department of Pediatrics, Rhode Island Hospital, Providence, RI  
Marie St. Cyr, Executive Director, Women and AIDS Resource Network, Brooklyn, NY  
Ronald St. John, M.D., M.P.H., National AIDS Program Office, Department of Health  
and Human Services, Washington, DC  
Jill Strawn, R.N., M.S.N., Director of Agency Outreach, Community Health Education  
Project, New Haven, CT  
John W. Ward, M.D., Special Assistant for Science (HIV), Centers for Disease Control,  
Atlanta, GA  
Robert White, Deputy Director, Blacks Educating Blacks About Sexual Health Issues  
(BEBASHI), Philadelphia, PA  
Wayne S. Wright, Executive Director, Multicultural AIDS Coalition, Boston, MA

**Report of the U.S. Bipartisan Commission on Comprehensive Health Care  
Review of The National Drug Control Strategy  
Washington, DC  
March 15, 1990**

***Report of the Pepper Commission***

Judith Feder, Executive Director, The Pepper Commission, Washington, DC  
Honorable Henry A. Waxman, Representative, State of California

***Drug Use and the HIV Epidemic***

Barry Brown, Ph.D., Chief, Community Research Branch, National Institute on Drug  
Abuse, Rockville, MD  
Harry Haverkos, M.D., Acting Director, Division of Clinical Research, National Institute  
on Drug Abuse, Rockville, MD  
Herbert D. Kleber, M.D., Deputy Director for Demand Reduction, Office of National  
Drug Control Policy, Washington, DC  
Beny J. Primm, M.D., Associate Administrator, Office for Treatment Improvement,  
Alcohol, Drug Abuse and Mental Health Administration, Washington, DC

***Housing and the HIV Epidemic***

Don C. Des Jarlais, Ph.D., Commissioner, National Commission on AIDS  
Honorable S. William Green, Representative, State of New York

**HIV/AIDS Research: Clinical Trials**  
**Washington, DC**  
**May 7-8, 1990**

**May 7**

***National Academy of Sciences Overview***

Samuel O. Thier, M.D., President, Institute of Medicine, Washington, DC  
Charles Turner, Ph.D., Director, Committee on AIDS Research and the Behavioral,  
Social, and Statistical Sciences, National Research Council, Washington, DC  
Robin Weiss, M.D., Director, AIDS Activities, Institute of Medicine, Washington, DC

***Drug Development and Approval Overview***

Ellen C. Cooper, M.D., M.P.H., Director, Division of Antiviral Drug Products, Food and  
Drug Administration, Rockville, MD  
John C. Petricciani, M.D., Vice President, Medical and Regulatory Affairs,  
Pharmaceutical Manufacturers Association, Washington, DC  
Gerald Quinnan, M.D., Deputy Director, Center for Biologics Evaluation and Research,  
Food and Drug Administration, Rockville, MD  
Joel Solomon, Ph.D., Director, Division of Blood and Blood Products, Center for  
Biologics Evaluation and Research, Food and Drug Administration, Rockville, MD

***National Institutes of Health Overview***

Anthony S. Fauci, M.D., Director, Office of AIDS Research, National Institutes of  
Health, Bethesda, MD  
Janet Heinrick, Dr.P.H., R.N., Director, Division of Extramural Programs, National  
Center for Nursing Research, Bethesda, MD  
Philip A. Pizzo, M.D., Chief of Pediatrics, Head, Infectious Disease Section, National  
Cancer Institute, Bethesda, MD

***Community Needs and Perspectives***

John Caldwell, Project Inform, San Francisco, CA  
Jim Eigo, M.F.A., ACT UP, New York, NY  
Luis Hernandez, Outreach Assistant Coordinator, Community Research Initiative,  
New York, NY  
Rosa Martinez, Pediatric AIDS Advocate, Tampa, FL  
Neil Schram, M.D., Chair, AIDS Task Force, American Association of Physicians for  
Human Rights, San Francisco, CA  
Sonia Singleton, Community Outreach Education and Prevention, Inc., Miami, FL

**May 8**

***Scientific and Care Community***

Donald I. Abrams, M.D., Chair and Principal Investigator, Community Consortium, San  
Francisco General Hospital, San Francisco, CA  
Gerald Friedland, M.D., Professor of Medicine, Epidemiology and Social Medicine,  
Albert Einstein College of Medicine, New York, NY

Cecelia Hutto, M.D., Assistant Professor of Infectious Diseases and Immunology,  
Department of Pediatrics, University of Miami School of Medicine, Miami, FL  
Mathilde Krim, Ph.D., Co-Chair, Committee on Research, National Organization  
Responding to AIDS, New York, NY  
Janet L. Mitchell, M.D., M.P.H., Chief of Perinatology, Department OB-GYN, Harlem  
Hospital Center, New York, NY  
Ronald Sable, M.D., Co-Founder, AIDS Program, Cook County Hospital, Chicago, IL  
Amy Simon-Kramer, R.N., M.P.A., National Hemophilia Foundation, New York, NY  
George Perez, M.D., Medical Director, North Jersey Community Research Initiative,  
Newark, NJ  
Melanie Thompson, M.D., President, AIDS Research Consortium of Atlanta, GA

***Research and Demonstration Projects***

Patricia McInturff, M.P.A., Director, Regional Division, Seattle-King County  
Department of Public Health, Seattle, WA  
Anita Vaughn, M.D., Medical Director, Newark Community Health Centers, Inc.,  
Newark, NJ  
John K. Watters, Ph.D., Assistant Adjunct Professor, Department of Epidemiology and  
Biostatistics, University of California, San Francisco, CA

**Working Group on Social/Human Issues**

**Dallas, TX**

**July 9-10, 1990**

**July 9**

***Facilitator***

Nancy Love, Ph.D.

Ron Anderson, M.D., President, Parkland Memorial Hospital, Dallas, TX  
Steven Bowen, M.D., Deputy Director for AIDS, Center for Prevention Services, Centers  
for Disease Control, Atlanta, GA  
John M. Dyer, M.D., M.P.H., Assistant Secretary of Health, Regional Office, Dallas, TX  
Donald P. Francis, M.D., D.Sc., Regional AIDS Advisor, California Department of  
Health Services, San Francisco, CA  
Gordon Green, M.D., M.P.H., Dallas County Health Commissioner, Dallas, TX  
Fernando A. Guerra, M.D., M.P.H., Director, San Antonio Metropolitan Health District,  
San Antonio, TX  
John R. Harkess, M.D., Assistant State Epidemiologist, Oklahoma State Department of  
Health, Oklahoma City, OK  
Robert E. Keller, STD/HIV Program Director, Metropolitan Health Department,  
Nashville, TN  
Ronald H. Levine, M.D., M.P.H., North Carolina State Health Director, Representative,  
Association of State and Territorial Health Officials, Washington, DC  
Robert MacLean, M.D., Deputy Commissioner, Texas Department of Health, Austin, TX

Henry L. Masters, III, M.D., Medical Director for AIDS/STD, Arkansas Department of Health, Little Rock, AR  
Louise McFarland, Dr.P.H., State Epidemiologist, Louisiana Department of Health and Hospitals, Baton Rouge, LA  
Christopher McNulty, D.O., Nelson-Tebedo Clinic, Dallas, TX  
Timothy Panzer, Executive Director, Valley AIDS Project, Harlingen, TX  
Frederick R. Pintz, M.D., Director, Division of Health Services Delivery, Region VI, Public Health Service, Dallas, TX  
Don Schmidt, Person Living with AIDS  
Jane Wilson, M.S., AIDS Prevention Coordinator, New Mexico Health and Environment Department, New Mexico Department of Health, Santa Fe, NM  
Fred Wolf, M.P.A., Chief, STD/AIDS Section, Colorado State Health Department, Denver, CO

#### July 10

Donna Antoine-Perkins, HIV Services Planning Project, Mississippi State Department of Health, Jackson, MS  
Warren Buckingham, AIDS ARMS Network, board member, Texas AIDS Network, Dallas, TX  
George R. Buchanan, Director, North Texas Comprehensive Hemophilia Center, Dallas, TX  
Eileen Carr, Dallas Urban League, Dallas, TX  
Roslyn Cropper, M.D., Desire Narcotics and Rehabilitation Center, New Orleans, LA (not present)  
Jean Derry, M.S.W., Field Operations Division, Oklahoma Department of Human Services, Tulsa, OK  
Robert Dixon, Texas Commission on Alcohol and Drug Addiction, Austin, TX  
Paula Elerick Espinosa, Southwest AIDS Committee, El Paso, TX  
Luis Fuentes, Amigos Volunteers in Education and Services (AVES), Houston, TX  
Deliana Garcia, Director of Special Projects, National Migrant Resource Program, Austin, TX  
John Hannan, Positive AIDS in Recovery, Dallas, TX  
Steve Hummel, Good Samaritan Project, Kansas City, MO  
Rebecca Lomax, M.S.W., M.P.H., Associated Catholic Charities of New Orleans, New Orleans, LA  
Henry L. Masters, III, M.D., Medical Director for AIDS/STD, Arkansas Department of Health, Little Rock, AR  
Jasmin Shirley Moore, M.S.P.H., Northwest Health Center, Fort Lauderdale, FL  
Barbara Aranda Naranjo, R.N., South Texas Children's AIDS Center, San Antonio, TX  
Timothy Panzer, Executive Director, Valley AIDS Council, Harlingen, TX  
Don Schmidt, Person Living with AIDS  
Janet Voorhees, M.P.H., Project Coordinator of Health Resources and Services Administration, HIV Services Planning Grant Director, University of New Mexico, Albuquerque, NM  
William Waybourn, Dallas Gay Alliance, Dallas, TX  
Ted Wisniewski, M.D., HIV Outpatient Program, Charity Hospital, New Orleans, LA

**HIV/AIDS Epidemic in Health Care Personnel and the Work Force**  
**Washington, DC**  
**July 18-19, 1990**

**July 18**

***Personnel and Work Force Overview***

Molly Cooke, M.D., Associate Professor of Clinical Medicine, University of California, San Francisco, CA  
Connie R. Curran, R.N., Ed.D., F.A.A.N., Health Care Consultant, The Curran Group, Chicago, IL  
Eli Ginzberg, Ph.D., Director, Conservation of Human Resources, Columbia University, New York, NY

***Recruitment and Retention***

Brig. Gen. Clara L. Adams-Ender, R.N., Chief, Army Nurse Corps, Falls Church, VA  
Caroline Bagley Burnett, Sc.D., R.N., Senior Consultant, Commission on the National Nursing Shortage, Health Resources and Services Administration, Rockville, MD  
Charles M. Helms, M.D., Ph.D., Associate Dean, University of Iowa School of Medicine, IA  
Ronald L. Jerrel, President, National Association of People with AIDS (NAPWA), Owensboro, KY  
Joyce V. Kelly, Ph.D., Associate Vice President for Clinical Services, Association of American Medical Colleges, Washington, DC  
Nicholas A. Rango, M.D., Director, New York State AIDS Institute, New York Department of Health, New York, NY  
Rene F. Rodriguez, M.D., President, Inter-American College of Physicians and Surgeons, New York, NY  
Caitlin C. Ryan, M.S.W., A.C.S.W., Director, AIDS Policy Center, IHPP, George Washington University, Washington, DC  
Carolyn H. Smeltzer, Ed.D., R.N., F.A.A.N., Vice President for Nursing, University of Chicago Hospitals, Chicago, IL

***Education and Training***

David K. Henderson, M.D., Associate Director for Quality Assurance, Warren G. Magnuson Clinical Center, National Institutes of Health, Bethesda, MD  
Harvey J. Makadon, M.D., Executive Director, Boston AIDS Consortium, Boston, MA  
Rose A. Walton, Ed.D., Chair, Allied Health Resources, State University of New York at Stony Brook, NY

**July 19**

***Minority Recruitment and Retention (H.R. 3240)***

Honorable Louis Stokes, Representative, 21st District, State of Ohio



***Federal Personnel and Work Force Overview***

Marilyn H. Gaston, M.D., Director, Division of Medicine, Bureau of Health Professions,  
Health Resources and Services Administration, Rockville, MD  
Fitzhugh Mullan, M.D., Director, Bureau of Health Professions, Health Resources and  
Services Administration, Rockville, MD

***Education and Training***

John Molinari, Ph.D., Chair, Curriculum Advisory Committee on Blood-Borne Infectious  
Diseases, American Association of Dental Schools, Detroit, MI  
Enid A. Neidle, Ph.D., Associate Executive Director for Scientific Affairs, American  
Dental Association, Chicago, IL  
Carol Raphael, Chief Executive Officer, The Visiting Nurse Service of New York, NY  
Raymond Scalettar, M.D., F.A.C.P., Member, Board of Trustees, American Medical  
Association, Chicago, IL

***Recruitment and Retention***

Floyd J. Malveaux, M.D., Ph.D., Associate Professor of Microbiology and Medicine,  
Howard University, College of Medicine, Board of Trustees, National Medical  
Association, Washington, DC

***Volunteers and the Work Force***

James Graham, J.D., LL.M., Administrator, Whitman Walker Clinic, Washington, DC  
Eric E. Rofes, Executive Director, Shanti Project, San Francisco, CA  
Laurie Sherman, Speakers Bureau Coordinator, AIDS Action Committee, Boston, MA

***Ethical Dilemmas for the Work Force***

Lawrence O. Gostin, J.D., Executive Director, American Society of Law and Medicine,  
Boston, MA  
Christine Grady, R.N., M.S.N., Nurse Consultant, National Center for Nursing Research,  
National Institutes of Health, Bethesda, MD  
Alvin Novick, M.D., Professor of Biology, Yale University, Mayor's Task Force on  
AIDS, New Haven, CT  
Vincent Rogers, D.D.S., M.P.H., Chair, Department of Community Dentistry, Temple  
University, Philadelphia, PA

***Working Group on Social and Human Issues***

**Seattle, WA**

**July 30, 1990**

***Examining the Range of Social and Human Services Needed by People Affected by the  
HIV/AIDS Epidemic***

Gail Barouh, Long Island Association for AIDS Care, Huntington, NY  
Sean Duque, Person Living with AIDS  
Jon Fuller, S.J., M.D., President, National Catholic AIDS Network, Jesuit Urban Center,  
Boston, MA  
Robert L. Greenwald, Esq., AIDS Action Committee, Boston, MA

Linda Meredith, ACT UP Women's Committee, Washington, DC  
Veneita Porter, Planned Parenthood, San Francisco, CA  
David Schulman, Esq., Deputy City Attorney, HIV/AIDS Discrimination Unit,  
Los Angeles City Attorney's Office, Los Angeles, CA  
David Woodring, Osage, National Native American AIDS Prevention Center,  
Albuquerque, NM

***Partnerships in Care: Examining the Seattle-King County Model***

***Lead Agency Model***

Nancy M. Campbell, Executive Director, Northwest AIDS Foundation, Seattle, WA  
P. Catlin Fullwood, Executive Director, People of Color Against AIDS Network,  
Seattle, WA

***Case Management Systems***

Margo Bykonnen, R.N., AIDS Outpatient Coordinator, Swedish Hospital Center,  
Seattle, WA  
Jeffrey Sakuma, M.S.W., Coordinator, Community Health Services Group Health  
Cooperative, Seattle, WA

***AIDS Intervention Programs for Substance Users***

Charlton Clay, Assistant Coordinator, Seattle Needle Exchange, Community AIDS  
Services Unit, Seattle-King County Department of Public Health, Seattle, WA  
Dave Purchase, Coordinator, Tacoma Needle Exchange, Tacoma, WA  
Robert Wood, M.D., AIDS Medical Director, AIDS Prevention Project, Seattle-King  
County Department of Public Health, Seattle, WA

***Housing Programs***

Harris Hoffman, Executive Director, AIDS Housing of Washington, Seattle, WA  
Patricia McInturff, M.P.A., Director, Regional Division, Seattle-King County  
Department of Public Health, Seattle, WA

***Partnerships in Care: Improving and Creating Partnerships in the Delivery of Social  
and Human Services***

Mirabelle Clements, Hemophilia Program, Puget Sound Blood Center, Seattle, WA  
Rene Durazzo, Director of Public Policy and Communications, San Francisco AIDS  
Foundation, San Francisco, CA  
Randy Gorbette, President, Phoenix Shanti Group, Phoenix, AZ  
Ronald Johnson, Executive Director, Minority Task Force on AIDS, New York, NY  
Deborah A. Lee, Association of Asian/Pacific Community Health Organizations,  
Oakland, CA  
John Pacheco, Minnesota Hispanic AIDS Partnership, St. Paul, MN  
Lorraine Teel, Minnesota AIDS Project, Minneapolis, MN  
Elizabeth Valdez, Concilio Latino de Salud, Phoenix, AZ

***Responsibilities and Roles of Governmental Agencies in the Development of Social and Human Services Networks***

Kristine M. Gebbie, R.N., Secretary, Washington State Department of Health,  
Olympia, WA

King Holmes, M.D., University of Washington, Seattle, WA

Adam Myers, M.D., Denver Department of Health and Hospitals, Denver, CO

Joseph O'Neill, M.D., M.P.H., Bureau of Health Care Delivery and Assistance, Division  
of Special Populations, Health Resources and Services Administration,  
Rockville, MD

**HIV Infection and AIDS in Correctional Facilities**

**New York, NY**

**August 16-17, 1990**

**August 16**

Eran Bellin, M.D., Director, Infectious Disease Services, Montefiore Rikers Island Health  
Service, New York, NY

Charles Braslow, M.D., Program Director, Montefiore Rikers Island Health Service,  
New York, NY

Nicholas Freudenberg, Professor, Hunter College, City University of New York, NY

Margaret Grossi, M.D., Deputy Commissioner of Health, New York City Department of  
Health, New York, NY

Wallace Rooney, M.D., Medical Director, Prison Health Service, New York, NY

Michael Tannenbaum, Acting Assistant Commissioner, Department of Prison Health  
Services, New York

Margaret Wishart, Administrator, Montefiore Rikers Island Health Service,  
New York, NY

Steve Zoloth, M.D., Epidemiologist, Rikers Island Health Service, New York, NY

**August 17**

***Introduction to Correction***

Mark Lopez, Esq., The National Prison Project, American Civil Liberties Union  
Foundation, Inc., Washington, DC

***Epidemiological Perspective***

Kenneth G. Castro, M.D., M.P.H., Medical Epidemiologist, AIDS Program, Centers for  
Disease Control, Health and Human Services, Atlanta, GA

***Health Care in the Correctional Setting***

Robert Cohen, M.D., Inpatient AIDS Services, St. Vincent Hospital, New York, NY

Kenneth Moritsugu, M.D., Medical Director for Department of Justice Federal Bureau of  
Prisons, Washington, DC

***Issues in Corrections: State Experiences***

Alexa Freeman, Esq., The National Prison Project, American Civil Liberties Union Foundation, Inc., Washington, DC  
Catherine Hanssens, Esq., Staff Attorney, Department of the Public Advocate, Office of Inmate Advocacy, Hughes Justice Complex, Trenton, NJ  
German V. Maisonet, M.D., Chief of HIV Services, California Medical Facility, Vacaville, CA  
Michael Wiseman, Esq., Prisoners Rights Project of the Legal Aid Society of New York, New York

***Women and HIV Infection***

Marilyn Rivera, AIDS Counseling and Education Project, New York, NY  
Brenda Smith, Esq., National Woman's Law Center, Washington, DC

***Presentation of Inmate Statements and Affidavits***

Judy Greenspan, The National Prison Project, American Civil Liberties Union Foundation, Inc., Washington, DC

***Inmate Access to Clinical Trials***

Ann Graham, Food and Drug Administration, Rockville, MD  
A. Billy S. Jones, Board member and Co-Chair, National Lawyer's Guild's AIDS Network and Washington Correctional Foundation, Washington, DC  
Robert J. Levine, M.D., Professor, Department of Internal Medicine, School of Medicine, Yale University, New Haven, CT  
Victoria Sharp, M.D., Medical Director, Spellman Center, St. Clairs Hospital, New York, NY

***HIV/AIDS Education***

Edward A. Harrison, Director of Planning, National Commission on Correctional Health Care, Chicago, IL  
Jose C. Hernandez, Executive Director, Project HACER, San Antonio, TX  
Sharon A. Lett, Deputy Director, Delaware Council on Crime and Justice, Wilmington, DE  
Lewis Tanner Moore, M.Ed., Prison AIDS Project, Detention Center, Philadelphia, PA

***Courts, Inmates, and HIV/AIDS Policy Making through Litigation***

Honorable Richard T. Andrias, Justice of New York State Supreme Court, New York  
Scott Burris, Esq., Staff Attorney, AIDS and Civil Liberties Project, American Civil Liberties Union of Pennsylvania, Philadelphia, PA  
J.L. Pottenger, Jr., Esq., Clinical Professor of Law, Jerome N. Frank Legal Service Organization, Yale Law School, New Haven, CT

***HIV/AIDS Release Policies***

Cathy Potler, Esq., Director, AIDS in Prison Project, Correctional Association of New York, New York, NY

Romeo Sanchez, Supervisor of Advocacy Issues, New York City Commission on Human Rights, AIDS Discrimination Division, New York, NY

**Public Health and the HIV Epidemic  
Washington, DC  
September 17-18, 1990**

**September 17**

***The Mission of Public Health***

Richard Remington, Ph.D., Professor of Biostatistics, Department of Preventive Medicine, University of Iowa, Institute of Medicine Committee for the Study of the Future of Public Health, Iowa City, IA

William L. Roper, M.D., M.P.H., Director, Centers for Disease Control, Atlanta, GA

David Satcher, M.D., Ph.D., President, Meharry Medical College, Nashville, TN

***The Public Health Response***

Suzanne Dandoy, M.D., M.P.H., Executive Director, Utah Department of Health, Association of State and Territorial Health Officials, Washington, DC, American College of Preventive Medicine, Salt Lake City, UT

Mark Magenheimer, M.D., M.P.H., Sarasota County Health Department, National Association of County Health Officials, Sarasota, FL

William Myers, M.S., Health Commissioner, Ohio Health Department, National Association of County Health Officials, Columbus, OH

***Risk Assessment***

James W. Curran, M.D., M.P.H., Division of HIV/AIDS, Centers for Disease Control, Atlanta, GA

Laurence Foster, M.D., M.P.H., M.S., Council of State and Territorial Epidemiologists, Portland, OR

J. Mehser Joseph, Ph.D., Association of State and Territorial Laboratory Directors, Baltimore, MD

***The Response of Community-Based Organizations***

Daniel T. Bross, AIDS Action Council, Washington, DC

Larry Kessler, Commissioner, National AIDS Commission, AIDS Action Committee, Boston, MA

**September 18**

***Prevention***

Allan M. Brandt, Ph.D., Department of Social Medicine, School of Medicine, University of North Carolina, Chapel Hill, NC  
Allan Rosenfield, M.D., Dean, Columbia University School of Public Health, New York, NY  
Ron Rowell, M.P.H., National Native American AIDS Prevention Center, Oakland, CA

***The Public Health System and Service Delivery***

Castulo de la Rocha, J.D., AltaMed Health Services Corporation, Los Angeles, CA  
Robert G. Harmon, M.D., M.P.H., Administrator, Health Resources and Services Administration, Rockville, MD  
Jasmin Shirley Moore, M.S.P.H., AIDS Patient Care Director, Department of Health and Rehabilitative Services, Broward County Public Health Unit, Northwest Health Center, Ft. Lauderdale, FL  
Steven A. Schroeder, M.D., President, The Robert Wood Johnson Foundation, Princeton, NJ  
Andrew Ziegler, M.H.S.A., National Association of People with AIDS, Washington, DC

***The Future of Public Health***

Caswell Evans, Jr., D.D.S., M.P.H., Los Angeles County Health Department, American Public Health Association, CA  
Kristine M. Gebbie, R.N., Secretary, Washington State Department of Health, Olympia, WA  
Woodrow A. Myers, Jr., M.D., M.B.A., Commissioner of Health, New York City Health Department, New York, NY  
Helen Rodriguez-Trias, M.D., Consultant in Health Programming, Brookdale, CA

**HIV/AIDS in Puerto Rico  
San Juan, Puerto Rico  
November 27-28, 1990**

**November 27**

Antonia Novello, M.D., U.S. Surgeon General, Washington, DC  
Jose E. Soler-Zapata, M.D., Secretary of Health, Puerto Rico Department of Health, San Juan, Puerto Rico

***HIV/AIDS Services in Puerto Rico***

Pedro A. Borrás, M.D., Director, San Juan Department of Health, San Juan, Puerto Rico  
Kenneth Castro, M.D., M.P.H., Assistant Chief, Epidemiology Branch, Division of HIV/AIDS, Centers for Disease Control, Atlanta, GA

Luis Maldonado Santos, Person Living with AIDS, Director, Proyecto Corazon, Ponce, Puerto Rico

Juan "Johnny" Rullan, M.D., M.P.H., Executive Director, AIDS Central Office, Puerto Rico Department of Health (PRDH), San Juan, Puerto Rico

#### ***Financing of Care***

Guillermo Otero, M.D., Subregional Director, U.S. Public Health Service, Puerto Rico

Jaime Rivera-Dueno, M.D., Executive Director, Instituto del SIDA de San Juan, Puerto Rico

Laura E. Torres, M.D., Acting Executive Director, Health Facilities and Services Administration, Puerto Rico Department of Health, San Juan, Puerto Rico

#### ***Availability of Clinical Trials and Experimental Drugs***

Jorge Irizarry, Person Living with AIDS, ACT UP, Puerto Rico

Carlos H. Ramirez-Ronda, M.D., F.A.C.P., Professor of Medicine, Chief, Medical Services, San Juan Department of Veteran Affairs Medical Center, San Juan, Puerto Rico

#### ***HIV/AIDS and Substance Abuse***

Honorable Hector Luis Acevedo, Mayor, City of San Juan, Puerto Rico

Henry Bodhwel, Resident, Hogar Crea las Americas, San Juan, Puerto Rico

Lydia Santiago, Resident, Hogar Crea las Americas, San Juan, Puerto Rico

Honorable Isabel Suliveres de Martinez, Secretary, Puerto Rico Department of Anti-Addiction Services (DAAS), Rio Piedras, Puerto Rico

#### ***Legal and Advocacy Issues***

Lydia Platón, Special Assistant, Disability Ombudsman for the Commonwealth of Puerto Rico, San Juan, Puerto Rico

Trina Rivera de Rios, Ph.D., President, Comité de Amigos y Familiares de Confinados, Inc., Puerto Rico

Nora Vargas, Esq. Sabana AIDS Litigation and AIDS Civil Rights Project, San Juan, Puerto Rico

Raul Villalobos, M.D., Executive Director, Correctional Health Program, Puerto Rico Department of Health, Rio Piedras, Puerto Rico

**November 28**

#### ***Migration Patterns and the HIV Epidemic***

Eunice Diaz, M.S., M.P.H., Commissioner, National Commission on AIDS

#### ***Human and Social Services***

Gladys Altieri, Ph.D., Special Assistant to the Secretary of Department of Social Services of Puerto Rico, San Juan, Puerto Rico

Joaquin Fernandez-Dumont, Liaison, Community-Based Organization, AIDS Central Office, Puerto Rico Department of Health, San Juan, Puerto Rico

Father Francisco Garcia, Albergue la Providencia, Ponce, Puerto Rico

José Núñez López, M.D., Assistant Secretary of Mental Health, Puerto Rico Department of Health, San Juan, Puerto Rico

José Toro, Ph.D., Executive Director, Fundacion SIDA, San Juan, Puerto Rico  
A Family Living with AIDS, Clinica de Servicios Pediátricos, Proyecto Amistad,  
Instituto del SIDA de San Juan, Departamento de Salud de la Capital, Puerto Rico

***Special Issues for Women and Children with HIV/AIDS***

Maria de los Angeles Calderon, Proyecto Tu, Mujer, Department of Anti-Addiction Services, Rio Piedras, Puerto Rico

Clemente Diaz, M.D., Principal Investigator, Proyecto Gamma, Children's Hospital, Medical Sciences Campus, University of Puerto Rico, Rio Piedras, Puerto Rico

Carmen Feliciano de Melecio, M.D., Director, Office Federal Programs, San Juan Health Department, San Juan, Puerto Rico

Nancy Santiago, M.D., Director, Health Resources and Services Administration, Pediatric AIDS Service Demonstration Project, Puerto Rico Department of Health, San Juan, Puerto Rico

Carmen D. Zorrilla, M.D., Co-Investigator, Women and Infant Transmission Study (WITS) Project, University Hospital, Medical Sciences Campus, University of Puerto Rico, Rio Piedras, Puerto Rico

***Prevention and Education Efforts***

Dr. Daisy Gely, M.P.H.E., Director, AIDS Education and Training Center, University of Puerto Rico, San Juan, Puerto Rico

Juan Morales, Coordinator, Education Programs, AIDS Central Office, Puerto Rico Department of Health, Hato Rey, Puerto Rico

Enrique Nieves, Coordinator, HIV/AIDS Prevention Program, Puerto Rico Department of Health, San Juan, Puerto Rico

Wilfredo Santiago, Director, Alto al SIDA, San Juan, Puerto Rico

**HIV Disease in African American Communities**

**Baltimore, MD**

**December 17, 1990**

***Overview***

Harlon Dalton, Esq., Commissioner, National Commission on AIDS

***Understanding a Legacy of Mistrust***

Alyce Gullattee, M.D., F.A.P.A., Howard University Hospital, Washington, DC

Mark D. Smith, M.D., M.B.A., Johns Hopkins University, School of Medicine, Baltimore, MD

Marie St. Cyr, M.S.W., Women and AIDS Resource Network, New York, NY

Alpha Thomas, Dallas Urban League, Dallas, TX



***Organizing African American Communities***

Elsie Cofield, AIDS Interfaith Network, Inc., New Haven, CT

Wilbert Jordon, M.D., M.P.H., Director, Office of Graduate Medical Education, King/Drew Medical Center, Los Angeles, CA

Sandra McDonald, President and Founder, Outreach, Inc., Atlanta, GA

Sonia Singleton, South Florida AIDS Network, Miami, FL

***Communities Working Together: Pitfalls and Promises of Coalition Building***

Keith Cylar, M.S.W., Minority Task Force on AIDS, New York, NY

P. Catlin Fullwood, Executive Director, People of Color Against AIDS Network, Seattle, WA

Phill Wilson, AIDS Coordinator, City of Los Angeles, CA

***Determining What is Culturally Appropriate***

Jacob Gayle, Ph.D., Special Assistant for Minority HIV Policy Coordination, Centers for Disease Control, Atlanta, GA

Rashidah Hassan, RNCIC, Executive Director, BEBASHI, Philadelphia, PA

Reggie Williams, Executive Director, National Task Force on AIDS Prevention, National Association of Black and White Men Together, San Francisco, CA

**Technical Briefing: Health Care Financing Issues**

**Baltimore, MD**

**December 18, 1990**

***Public Financing***

Karen Davis, Ph.D., Department of Health Policy and Management, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, MD

***Private Financing***

Mary Ann Bailey, Ph.D., Adjunct Associate Professor of Economics and Public Policy, Departments of Economics and Health Care Sciences, George Washington University and Medical School, Washington, DC

***Specific Issues for HIV Disease***

Honorable Kurt L. Schmoke, Mayor, Baltimore, MD

Bruce Vladeck, Ph.D., President, United Hospital Fund, New York, NY

***Roundtable Discussion about Practical Applications of Financing Mechanisms for HIV Disease***

Mary Ann Bailey, Ph.D., Adjunct Associate Professor of Economics and Public Policy, Departments of Economics and Health Care Sciences, George Washington University and Medical School, Washington, DC

Karen Davis, Ph.D., Department of Health Policy and Management School of Hygiene and Public Health, Johns Hopkins University, Baltimore, MD

Penelope L. Pine, Health Care Financing Administration, Department of Health and Human Services, Baltimore, MD

Bernard Pont, Field Representative, Social Security Administration, Baltimore, MD  
Steven Sieverts, M.P.H., Vice President for Health Care Finance, Blue Cross and Blue  
Shield of the National Capital Area, Washington, DC  
Bruce Vladeck, Ph.D., President, United Hospital Fund, Boston, MA

**HIV Disease and Substance Abuse**  
**Washington, DC**  
**January 17, 1991**

*Introduction to HIV Disease and Substance Use Issues*

Don Des Jarlais, Ph.D., Commissioner, National Commission on AIDS

*Review of Federal Government's Role and Responsibilities*

Linda N. Lewis, M.A., Office of Demand Reduction, Office of National Drug Control  
Strategy, Executive Office of the President, Washington, DC

*Report on the National Conference on HIV and Substance Abuse: Federal/State  
Strategies*

Beny Primm, M.D., Associate Administrator, Office for Treatment Improvement,  
Alcohol, Drug Abuse and Mental Health Administration, Rockville, MD

*HIV and Substance Use Prevention Issues*

Edmund H. Baca, Jr., M.A., LPC, Frio Street Project, San Antonio, TX  
Robert Fullilove, Ed.D., Director, HIV Center for Clinical and Behavioral Studies,  
Community Core, Psychiatric Institute, New York, NY  
Robert L. Johnson, M.D., Adolescent Medicine, University of Medicine and Dentistry of  
New Jersey, Newark, NJ  
Jose L. Perez, Public Policy Specialist, AIDS Project Los Angeles, CA  
Ray L. Stephens, Assistant Director for Program Development, Division of Alcohol and  
Drug Abuse Prevention, Little Rock, AR

*Reaching People Not In Treatment*

Dave Purchase, Coordinator, Point Defiance AIDS Project, Tacoma, WA  
Yolanda Serrano, Executive Director, Association of Drug Abuse Prevention and  
Treatment (ADAPT), New York, NY  
Sandra Vining-Bethea, Deputy Director for Outreach, Bridgeport Women's Project,  
Bridgeport, CT  
Yvette, Person Living with AIDS

*Availability of Drug Treatment: Meeting the Demand*

David H. Mulligan, Commissioner, Massachusetts Department of Public Health,  
Boston, MA  
Robert G. Newman, M.D., President, Beth Israel Medical Center, New York, NY  
James L. Sorensen, Ph.D., Chief, Substance Abuse Services, San Francisco General  
Hospital, San Francisco, CA  
Ann Thompson, Person Living with AIDS

***Substance Use, HIV and Primary Care: A Comprehensive and Integrated Approach***

Molly Joel Coye, M.D., M.P.H., Director, Division of Public Health, Johns Hopkins

University School of Hygiene and Public Health, Baltimore, MD

Iris L. Davis, M.D., New York Hospital/Cornell Medical Center, Center for Special

Studies, New York, NY

LaShaun Evans, DC Women's Council on AIDS, Washington, DC

Peter A. Selwyn, M.D., M.P.H., Montefiore Medical Center, Bronx, NY

**HIV Disease in Native American Communities**

**Arizona and New Mexico Site Visits**

**February 25-26, 1991**

**February 25**

***Welcoming Remarks***

Acardio Gastelum, Chairman, Pascua-Yaqui Tribe, Tucson, AZ

Andrew Lorrentine, Acting Director, Tohono O'odham Health Department, Sells, AZ

Dr. Floyd H. Martinez, Executive Director, La Frontera Center, Inc., Tucson, AZ

***La Frontera Center***

Arlene Joaquin, AIDS Thuth Mu'a O'odham AIDS Education Project, La Frontera Center, Inc., Tucson, AZ

Margo Cowan, M.S.W., J.D., AIDS Coordinator, La Frontera Center, Inc., Tucson, AZ

Francine Madsen-Montana, The Hope Center, Tucson, AZ

Gloria Nez, AIDS Thuth Mu'a O'odham AIDS Education Project, La Frontera Center, Inc., Tucson, AZ

***Pascua-Yaqui Nation, New Pascua***

Patricia Gallegos, El Rio Health Center, AIDS Prevention Program, Tucson, AZ

Gloria Garcia, Pascua-Yaqui Tribe, HIV Health Education Program, Tucson, AZ

Lois Steele, M.D., Clinical Director, Pascua-Yaqui Health Department, Tucson, AZ

***Tohono O'odham Nation, Tohono O'odham Health Department***

Rosemary Lopez, Tohono O'odham Health Department, Sells, AZ

Muriel Secundo, Tohono O'odham Health Department, Sells, AZ

***Sells U.S. Public Health Service Indian Hospital***

Thomas Tyma, M.D., AIDS Coordinator, Sells PHS Indian Hospital, Sells, AZ

Robert Wirth, M.D., Clinical Director, Sells PHS Indian Hospital, Sells, AZ

**February 26**

Melvin Harrison, Central Navajo AIDS Coalition, Chinle, AZ

***Navajo Nation President's Office Complex***

Vivian Arviso, Navajo Nation President's Office, Window Rock, AZ  
Larry Curly, Executive Director, Navajo Division of Health, Window Rock, AZ  
Anita Yazzi, AIDS Coordinator, Navajo Area Indian Health Service,  
Window Rock, AZ

***Gallup Indian Medical Center, Nizhoni Boulevard, Gallup, NM***

Larry Foster, Social Hygiene Department, Gallup Indian Medical Center, Gallup NM  
Ronald Porter, Indian Community Health Service, Phoenix, AZ  
Kathleen Stone, AIDS Program Manager, Arizona Department of Health Services,  
Phoenix, AZ

**HIV Disease and the American Indian/Alaskan Native Communities  
Minnesota and South Dakota Site Visits  
February 27-28, 1991**

**February 27**

Lori Beaulieu, Training Coordinator, National Native American AIDS Prevention Center,  
Minneapolis, MN  
Sharon Day, Executive Director, Minnesota American Indian AIDS Task Force,  
Minneapolis, MN  
Carole LaFavor, Person Living with AIDS  
Norman Landsem, AIDS Coordinator, Bemidji Area Office, Indian Health Service,  
Bemidji, MN

***Minnesota State-wide Indian Services Organizations***

Performance of "Ni Nokomis Zagayug" (My Grandmother's Love) by The Ogitchidag  
Gekinoamaagad Players  
Terrance Booth, Program Manager, Alaska Native Health Board, Anchorage, AK  
Sally Milroy, Program Administrator, Shakopee Mdewakanton Sioux Community, Prior  
Lake, MN  
Greg Moses, Yukon Kuskokwin Health Corps, Bethel, AK  
Joan Myrick, AIDS Coordinator, American Indian Health Care Association, St. Paul, MN  
Leonard Prescott, Chair, Shakopee Mdewakanton Sioux Community, Prior Lake, MN  
René Whiterabbit, AIDS Coordinator, Minneapolis Indian Health Board,  
Minneapolis, MN

***Wisconsin Winnebago Health and Human Services Division, the Great Lakes Inter-  
Tribal Council, and the Minnesota Tribal AIDS Coordinators***

**February 28**

Charon Asetoyer, Native American Women's Health Education Resource Center, South  
Dakota  
Willy Bettelyoun, Person Living with AIDS

Lorelei DeCora, R.N., Person Living With AIDS  
Cecilia Fire Thunder, Director of Health Services, Pine Ridge Reservation, Martin, SD

#### **Undated**

Star Ames-Nielsen, AIDS Coordinator, Great Lakes Inter-Tribal Council, Lac du Flambeau, WI  
Kathleen Annette, M.D., Area Director, Bemidji Area Office, Indian Health Service, Bemidji, MN  
Charon Asetoyer, Director, Native American Womens' Health Education Resource Center, Lake Andes, SD  
Rachelle Danelle, AIDS Coordinator, Ponemah Clinic, Ponemah, MN  
Roger Head, Director, Minnesota Indian Affairs Council, St. Paul, MN  
Robert Peacock, Chairman, Fond du Lac Reservation Business Council, Cloquet, MN  
Dr. Vijay Prabhaker, Winnebago Tribe Health Director, Department of Health and Human Services, Tomah, WI  
Mike Snedrud, P.H.N., Health and Human Services Division, Fond du Lac Reservation, Cloquet, MN  
JoAnne Stately, Minnesota Indian Affairs Council, St. Paul, MN  
Darrell Wadena, Chair, Minnesota Chippewa Tribe, White Earth, MN  
René Whiterabbit, AIDS Coordinator, Minneapolis Indian Health Board, Minneapolis, MN  
Paula Woods, P.H.N., White Earth Reservation AIDS Program, Bagley, MN

#### **HIV Disease and the Native American Communities**

##### **Oklahoma Site Visits**

**February 27-28, 1991**

Gloria Bellymule, R.N., Oklahoma City Indian Health Clinic, Oklahoma City, OK  
Curtis L. Harris, AIDS Coordinator, American Indian Community House, New York, NY

##### ***Intertribal AIDS Coalition***

Emma Autaubo, EMS Coordinator, Caddo Tribe  
Debra L. Birney, CHR Coordinator, Absentee Shawnee Tribe  
Richard Chalopah, Kiowa Tribe Alcohol Program  
Margaret Enright, Planned Parenthood, Oklahoma City, OK  
Alfred Franklin, Cheyenne-Arapaho Treatment Center  
Frances Harrison, CHR Coordinator, Wichita Tribe  
Ruth Jenks, Absentee Shawnee Tribe  
Michelle Jensen, U.S. Public Health Service, Indian Health Center, Anadarko, OK  
Marquita Kickapoo, Absentee Shawnee Tribe  
Shae Kinnaman, CH/AIDS Educator  
Marsha Lindsey, STAR Unit Outreach, Comanche County Memorial Hospital, Lawton, OK  
Rob Meyers, U.S. Public Health Service, Indian Health Center

Yvonne Monetathchi  
Sherrie Nowlin, Oklahoma Alliance Against Drugs, Lawton, OK  
Doris Olivor, CHR  
Marcella Panana, Cheyenne and Arapaho Tribes  
Glenn Starr, Cheyenne Tribe  
Jan Vassar, Sac & Fox Historian  
Frank Wahpepah, Sac & Fox Tribal Health Director  
Flora Weryackwe, Ft. Sill Apache Tribe

***Cherokee Nation of Oklahoma***

Col. Brenda Cummings, R.N., Administrator, Indian Health Care Resource Center,  
Tulsa, OK  
Truman Geren, L.P.N., AIDS Coordinator, Indian Health Care Research Center,  
Tulsa, OK  
Pamela Irons, Director, Health and Human Services, Cherokee Nation of Oklahoma,  
Tahlaquah, OK  
Stephen Short, M.D., W.W. Hastings Indian Hospital, Tahlequah, OK  
Dixie Stewart, R.N., B.S., AIDS Coordinator, HHS, W.W. Hastings Indian Hospital  
Tahlequah, OK  
Ellen Wolfe, P.H.N., Claremont Hospital

***Comanche Nation***

Teresa Lopez, Director, Comanche Tribe Substance Abuse Program, Lawton, OK  
Kenneth Saupity, Tribal Chairman  
Bonnie Turner, Tribal Administer

***Creek Nation of Oklahoma***

Sherry Baker, R.N., Director, Public Health Nurses  
Kathryn Bell  
Thomas Berryhill, Member, Creek National Council  
Shelly Crow, R.N., Chair, Creek Nation Health Board  
Sally Foster, Administrator, Creek Nation Healthcare System  
Ed Frye  
Toni Hill, Tribal Town Leader  
David Smith, D.O., Chief, Medical Staff, Eufala Clinic  
Kathy Stubbs, D.O.

***Sac and Fox Tribes***

Gaylon R. Franklin, Sr., Second Chief, Stroud, OK  
Elmer Manatowa, Principal Chief, Sac and Fox Tribes, Stroud OK

***Indian Health Service***

Pat Gideon, M.D., AIDS Coordinator, Oklahoma Area Office, Oklahoma City, OK

## **HIV Disease in Hispanic Communities**

**Chicago, Illinois**

**March 12, 1991**

### ***Framing the Problem***

Aida Giachello, Ph.D., Acting Regional Director, Midwest Hispanic AIDS Coalition,  
Chicago, IL

### ***Prevention***

Hortensia Amaro, Ph.D., Associate Professor, Boston University School of Public Health,  
Boston, MA

America Bracho, M.D., M.P.H., AIDS Coordinator, Latino Family Center, Detroit, MI

Illeana C. Herrell, Ph.D., Assistant Director for Minority Health, Center for Prevention  
Services, Centers for Disease Control, Atlanta, GA

Adolfo Mata, Public Health Advisor, Center for Prevention Services, Centers for Disease  
Control, Atlanta, GA

### ***Services***

Paula Amaro, Person Living with AIDS

Emilio Carrillo, M.D., President, New York Health and Hospitals Corporation, New  
York, NY

Manual Fimbres, A.C.S.W., San Jose State University, Fremont, CA

Nilsa Gutierrez, M.D., Associate Medical Director, New York AIDS Institute,  
New York, NY

### ***Migrant, Rural, and Undocumented Populations***

Barbara Garcia, Salud Para la Gente, Watsonville, CA

Deliana Garcia, Director of Special Projects, National Migrant Resource Program,  
Austin, TX

Samuel Martinez, Corporate Vice President, Migrant Child Institute, Washington State  
Migrant Council, Sunnyside, WA

### ***Policy and Leadership Issues***

Miguel Gomez, Director, AIDS Center, National Council of La Raza,  
Washington, DC

Miguelina Maldonado, M.S.W., Executive Director, Hispanic AIDS Forum,  
New York, NY

Alberto Mata, Ph.D., Senior Advisor, Division of Applied Research, National Institute on  
Drug Abuse, Rockville, MD

Helen Rodriguez-Trias, M.D., Consultant in Health Programing, Brookdale, CA

John Zamora, Minority HIV Education Specialist, HIV Division, Bureau of HIV and  
STD Control, Texas Department of Health, Austin, TX

**Adolescents and HIV Disease**  
**Chicago, Illinois**  
**March 13, 1991**

***Youth Issues***

Susan Castillo, Youth Advocates Teen HIV Program, San Francisco, CA  
Anthony Dekker, D.O., Director, Adolescent Medicine at Chicago Osteopathic,  
Adolescent Medicine at Rush Preston, St. Lukes, Chicago, IL  
DiAna DiAna, President and Executive Director, South Carolina AIDS Education  
Network, Columbia, SC  
Mindy T. Fullilove, M.D., NY State Psychiatric Institute, and Columbia University, HIV  
Center for Clinical and Behavioral Studies, New York, NY  
Donna Futterman, M.D., Medical Director, Adolescent AIDS Program, Montefiore  
Medical Center, New York, NY  
David Kamens, Teen Educator and Youth Advocate, Person Living with AIDS,  
Washington, DC  
Frances Kunreuther, Executive Director, Hetrick-Martin Institute for Lesbians and Gay  
Youth, New York, NY  
Su Neuhauser, M.A., Office of AIDS Prevention, Chicago Department of Health,  
Chicago, IL  
Jackie Sadler, M.P.H., Director, DC Public Schools HIV/AIDS Education Program,  
Washington, DC  
S. Kenneth Schonberg, M.D., Director, Division of Adolescent Medicine, Montefiore  
Medical Center and Albert Einstein College of Medicine, New York, NY

***Youth Panel***

Maria Bades, Youth Advocates, Teen HIV Program, San Francisco, CA  
Jamata Gray, Youth Advocates, Teen HIV Program, San Francisco, CA  
Sally Graham, Stop AIDS, Chicago, IL  
Lynn Hayes, Stop AIDS, Chicago, IL  
Hadley Hudson, Youth Advocates, Teen HIV Program, San Francisco, CA  
Cory Jacobs, Youth Advocates, Teen HIV Program, San Francisco, CA  
Nina Nicolette Lira, Youth Advocates, Teen HIV Program, San Francisco, CA (not  
present)  
Jovanna Quinn, Stop AIDS, Chicago, IL  
Kate Smith, Stop AIDS, Chicago, IL  
Kianja Stroud, Washington, DC  
Shelly, Cook County Hospital, Chicago, IL  
Robert Whitfield, Creedmoor, NC  
David Kamens, Teen Educator and Youth Advocate, Person Living with AIDS,  
Washington, DC

***Health Care Issues/Medical Dilemmas***

Janie Eddy, R.N., Children's National Medical Center, Washington, DC  
Elizabeth C. Gath, M.D., Cook County Hospital, Chicago, IL  
Margaret C. Heagarty, M.D., Director and Professor of Pediatrics, Columbia University,  
Harlem Hospital Center, New York, NY (not present)



Hermann Mendez, M.D., SUNY Health Sciences at Brooklyn, New York, NY  
Sheila Swain, Iowa

***Social and Family Issues***

Ana Garcia, L.C.S.W., Department of Pediatrics, University of Miami School of  
Medicine, Miami, FL  
Joan McCarley, M.S.W., Terrific Inc., Grandma's House, Washington, DC  
Toni P., Person Living with AIDS  
Barbara J. Sabol, R.N., Commissioner, New York City Department of Human Resources,  
New York, NY (not present)  
Dottie Ward-Wimmer, R.N., Children's National Medical Center, Washington, DC

**Financing Health Care for Persons with HIV Infection and AIDS: Policy  
Options  
Washington, DC  
April 22-23, 1991**

Chris Beyrer, M.D., Preventive Medicine Resident, Johns Hopkins School of Public  
Health, Baltimore, MD  
Ron Bialek, M.P.P., Director, Health Program Alliance, Instructor, Department of Health  
Policy and Management, Johns Hopkins School of Public Health, Baltimore, MD  
Patrick Chaulk, M.D., Chief Preventive Medicine Resident, Johns Hopkins School of  
Public Health, Baltimore, MD  
Rose Chu, M.B.A., Economist, Actuarial Research Corporation, Annandale, VA  
Peter Cowley, M.D., Preventive Medicine Resident, Johns Hopkins School of Public  
Health, Baltimore, MD  
Molly Joel Coye, M.D., M.P.H., Director, Division of Public Health, Johns Hopkins  
University School of Hygiene and Public Health, Baltimore, MD  
Patricia E. Franks, Coordinator, AIDS Resource Programs, Institute of Health Policy  
Studies, University of California, San Francisco, CA  
Robert Fullilove, Ed.D., Director, HIV Center for Clinical and Behavioral Studies,  
Community Core, Psychiatric Institute, New York, NY  
Karen Davis, Ph.D., Professor and Chairman, Department of Health Policy and  
Management, Johns Hopkins School of Public Health, Baltimore, MD  
Jennifer Harlow, M.H.S., Research Associate, Johns Hopkins School of Public Health,  
Baltimore, MD  
Philip R. Lee, M.D., Director, Institute of Health Policy Studies, University of California  
School of Medicine, San Francisco, CA  
Harvey J. Makadon, M.D., Executive Director, Boston AIDS Consortium, Boston, MA  
Jeffrey Stryker, University of California, San Francisco, CA  
Holly Taylor, M.P.H., Staff Member, National Commission on AIDS, Washington, DC  
Timothy Westmoreland

**HIV Disease in Sexual Identified Communities  
San Francisco, California  
May 16, 1991**

Honorable Art Agnos, Mayor, City of San Francisco, CA  
Larry Kessler, Commissioner, National Commission on AIDS

***American Society and Sexuality***

Reginald Fennell, Ph.D., Assistant Professor, Miami University, Oxford, OH  
David Lourea, Ed.D., San Francisco, CA  
Pepper Schwartz, Ph.D., Office of the Provost, University of Washington, Seattle, WA

***The Experience of "Sexually-Identified" Communities***

Autumn Courtney, San Francisco, CA  
Paul Davis, Minority AIDS Project, Los Angeles, CA  
Marjorie Hill, Ph.D., Director, Mayor's Office to the Lesbian and Gay Community,  
New York, NY  
Sue Hyde, Cambridge, MA  
Richard La Fortune, Minneapolis Indian Health Board, Minneapolis, MN  
Eric E. Rofes, Executive Director, Shanti Project, San Francisco, CA

***The Response of "Sexually-Identified" Communities to the HIV Epidemic***

David Barr, Gay Men's Health Crisis, New York, NY  
Paul Bonenberg, Mobilization Against AIDS, San Francisco, CA  
Jerome Boyce, Project Survival, Detroit, MI  
Valli Kanuha, M.S.W., Hetrick-Martin Institute, New York, NY  
Jose L. Perez, AIDS Project Los Angeles, CA  
Maxine Wolfe, Activist, Brooklyn, NY

***Sexuality, HIV, and Government Policy***

Daniel T. Bross, Director, AIDS Action Council, Washington, DC  
Miguel Gomez, Director, AIDS Center, National Council of La Raza, Washington, DC  
Tim McFeeley, Executive Director, Human Rights Campaign Fund, Washington, DC  
Tim Offutt, Minority Initiatives Coordinator, San Francisco Department of Health,  
San Francisco, CA  
Carmen Vasquez, M.S.Ed., Coordinator of Lesbian and Gay Health Services, San  
Francisco Department of Health, San Francisco, CA

**HIV Disease and Asian, Asian American, and Pacific Islander Communities  
San Francisco, CA  
May 17, 1991**

Paul Kawata, Washington, DC

***Historical Perspective***

Tessie Guillermo, Asian American Health Forum, San Francisco, CA  
Gen Inuma, Department of Health, Wialuku, HI  
Suki Ports, New York, NY

***Impact of HIV Disease Among Asians, Asian Americans, and Pacific Islanders***

***Moderator***

Jane Po, Gay Men's Health Crisis, New York, NY

Kiki Ching, San Francisco, CA  
Lei Chou, Jersey City, NJ  
Billy Gill, San Francisco, CA  
Martin Hiraga, Washington, DC  
Sharon Lim-Hing, Summerville, MA  
Sinh Nguyen, People of Color Against AIDS Network (POCAAN), Seattle, WA  
Robby Robison, San Francisco, CA  
Merina Sapolu, Honolulu, HI  
Paul Shimazaki, San Francisco, CA  
Velma Yemota, San Francisco, CA

***Provision of Services***

***Moderator***

Fernando Chang-Muy, Legal Counselor, Office of U.N. High Commissioner for  
Refugees, Washington, DC

Wayne Antkowiak, Department of Public Health and Social Services, Agana, Guam  
Jaime Geaga, San Francisco, CA  
Dean Goishi, Project Director, Asian/Pacific Lesbians and Gays, Los Angeles, CA  
Kerrily Kitano, University of Hawaii, Student Health Service, Honolulu, HI  
Lori Lee, San Francisco, CA  
John Manzon, Brooklyn, NY  
Nga Nguyen, McLean, VA  
Tony Nguyen, Center for Southeast Asian Resettlement, San Francisco, CA  
Joanna Omi, New York, NY  
Dorothy Wong, San Francisco, CA

**Women and HIV**

**Denver, CO**

**June 5, 1991**

***Women Living With HIV Disease***

Lorelei Estrada  
Frankie Mason  
JoAnne Suiter

### ***HIV Disease in Women***

- Kathryn Anastos, M.D., Medical Director, HIV Primary Care Services, Bronx-Lebanon Hospital Center, Bronx, NY  
Mary Young, M.D., Director, HIV Women's Program, Georgetown University Medical Center, Washington, DC  
Carmen D. Zorrilla, M.D., Associate Professor, Obstetrics and Gynecology Department, University of Puerto Rico School of Medicine, San Juan, Puerto Rico

### ***Psychosocial Issues***

- Inca Mohamed, Adolescent Program Specialist, YWCA of the USA, New York, NY  
Alva A. Moreno, Staff Research Associate, University of California, San Francisco, California Partner Study, Alhambra, CA  
Veneita Porter, Director of Education for Planned Parenthood, San Francisco, CA, Former Director, New York State Division of Human Rights, Office of AIDS Discrimination Issues, New York, NY (not present)  
La Francis Rodgers-Rose, Ph.D., President, International Black Women's Congress, Newark, NJ  
Ruth Slaughter, Director, AIDS Division, Women and AIDS Risk Network (WARN), Los Angeles, CA

### ***Prevention Strategies***

- Lori Beaulieu, Training Coordinator, Native American AIDS Prevention Center, Minneapolis, MN  
Dazon Dixon, Executive Director, SISTERLOVE: Women's AIDS Project, Atlanta, GA  
Anke A. Ehrhardt, Ph.D., Professor, Department of Psychiatry, Columbia University, Director, HIV Center for Clinical and Behavioral Studies, New York State Psychiatric Institute, New York, NY  
Colette Jacques, R.N., Founder and Executive Director, Support Organization for AIDS Prevention (SOAP), Los Angeles, CA  
Carmen Paris, AIDS Program Director, Association of Puerto Ricans on the March, Philadelphia, PA  
Zena Stein, M.D., Associate Dean for Research, Columbia University School of Public Health, Co-Director, HIV Center for Clinical and Behavioral Studies, New York State Psychiatric Institute, New York, NY

### ***Service Needs***

- Lydia Allen, R.N., Person Living with AIDS  
Judith Cohen, Ph.D., Director, Association for Women's AIDS Research and Education (AWARE), San Francisco, CA  
Yvonne Hutchinson, R.N.P., M.A., National Black Nurses Association, Spring Valley, CA  
S. Denise Rouse, M.P.H., Director, DC Women's Council on AIDS, Washington, DC

### ***Research***

- Mary Lucey, ACT UP, Seattle, WA  
Janice Jirau, Washington, DC

Vickie M. Mays, Ph.D., Department of Psychology, University of California,  
Los Angeles, CA

Constance Wofsy, M.D., Professor of Clinical Medicine, University of California, San  
Francisco, San Francisco General Hospital, San Francisco, CA

**Civil Rights and HIV Disease**  
**Denver, CO**  
**June 7, 1991**

*Overview of Civil Rights Issues*

Nan D. Hunter, J.D., Associate Professor, Brooklyn Law School, Brooklyn, NY

*Civil Rights and the HIV Epidemic*

Matthew Coles, Staff Attorney, American Civil Liberties Union of Northern California,  
San Francisco, CA

Curtis Decker, Executive Director, National Association of Protection and Advocacy  
Systems, Co-Chair, National Organization Responding to AIDS Civil Rights Task  
Force, Washington, DC

Vada Kyle-Holmes, Regional Manager, Office for Civil Rights, Department of Health  
and Human Services, Region VIII, Denver, CO

Norman H. Nickens, Esq., Coordinator, San Francisco Human Rights Commission, San  
Francisco, CA

Katherine O'Neill, HIV/AIDS Policy Director, Legal Action Center, and Legal Services  
Director, New York, NY

William B. Rubenstein, Director, American Civil Liberties Union, National AIDS  
Project, New York, NY

Carlos Santistevan, People of Color Against AIDS, Denver, CO

Thomas B. Stoddard, Executive Director, Lambda Legal Defense and Education Fund,  
Inc., New York, NY

Barry Sullivan, Esq., Chair, Coordinating Committee on AIDS, American Bar  
Association, Chicago, IL

Phillip Wiley, Broken Arrow, OK

**Working Group on Religious Communities**  
**Washington, DC**  
**August 26, 1991**

*Facilitator*

Maryann G. Hedaa

Sunny Rumsey Ahmed, Deputy Director, Minority AIDS Task Force, New York, NY

Rev. Scott W. Alexander, Unitarian Universalist Association, Boston, MA

Rev. Thaddeus Bennett, National Episcopal AIDS Coalition, AIDS Ministries of  
Connecticut, Hartford, CT

Rev. Paul H. Desrosiers, Catholic Archdiocese, Lacombe, LA

Dr. Elias Farjate-Jones, Assistant Professor, Howard University School of Divinity,  
Washington, DC

Rev. Leroy Augustus Fountain, Southlawn Baptist Church, Montgomery, Alabama

Jon Fuller, S.J., M.D., President, National Catholic AIDS Network, Jesuit Urban Center,  
Boston, MA

Joel Guajardo, Ph.D., Director, Minority AIDS Project, Lincoln, NE

Chaplain Samuel Geli, National College of Chaplains, Santa Monica, CA

Rev. Robert E. Hensley, Director of Pastoral Services, AIDS Interfaith Network of North  
Texas, Dallas, TX

Bishop Dr. Sherman G. Hicks, Metropolitan Chicago Synod, Evangelical Lutheran  
Church in America, Chicago, IL

Dr. William Johnson, Secretary, AIDS Programs and Ministries, Board of Homeland  
Ministries, United Church of Christ, Cleveland, OH

Rabbi Sharon A. Kleinbaum, Director, Congregational Relations, Religious Action  
Center of Reform Judaism, Washington, DC

Cathie Lyons, Associate General Secretary of Health and Welfare, Ministries Program  
Department, United Methodist Church, New York, NY

Holly McAlpen, President, National Episcopal AIDS Coalition, San Francisco, CA

Maurice O'Brian Franklin, National Director, National AIDS Awareness Program,  
Southern Christian Leadership Conference for Women, Atlanta, GA

Rev. A. Stephen Pieters, Los Angeles, CA

Rev. Cheryl Price, Executive Director, Congress of National Black Churches,  
Washington, DC

Rev. Kenneth T. South, Executive Director, National AIDS Interfaith Network,  
Washington, DC

Kenneth R. Williams, Chief, National Partnerships Development, National AIDS  
Information and Education Program, Centers for Disease Control, Atlanta, GA

**Making the Health Care Environment Safer: Strategies to Reduce the Risk of  
Transmission of Bloodborne Infections  
Washington, DC  
November 5, 1991**

***The CDC Perspective***

William L. Roper, M.D., M.P.H., Director, Centers for Disease Control, Atlanta, GA

***Policy Considerations***

Jeremiah Barondess, M.D., President, New York Academy of Medicine, New York, NY

***Overview***

Mark D. Barnes, J.D., L.L.M., Associate, Shearman and Sterling, New York, NY

***The Dimensions of Risk***

Julie L. Gerberding, M.D., Ph.D., Assistant Professor, San Francisco General Hospital,  
University of California, San Francisco, CA

Barbara Fassbinder, R.N., B.S.N., Cedar Rapids, IA

Barbara Gerbert, Ph.D., Associate Professor and Chair, Behavioral Science Division,  
School of Dentistry, University of California, San Francisco, CA  
Michael Osterholm, Ph.D., M.P.H., State Epidemiologist and Chief, Acute Disease  
Epidemiology Section, Minnesota Department of Health, Minneapolis, MN

***The Social and Ethical Implications***

Gabor Kelen, M.D., Associate Professor and Research Director, American College of  
Emergency Physicians, Associate Professor and Research Director, Department of  
Emergency Medicine, Johns Hopkins University Hospital, Baltimore, MD  
Donald G. Hagan, M.D., Physician, Laguna Beach, CA  
Richard Martin, M.D., Medical Consultant, Tampa, FL  
Bobbie J. Primus, Ed.D., M.P.H., R.N., Associate Professor of Nursing, Coordinator,  
Special Projects Department of Nursing, University of Central Florida, Daytona  
Beach, FL

***Legal and Regulatory Aspects***

David Barr, J.D., Assistant Director for Policy, Gay Men's Health Crisis, New York, NY  
Chai R. Feldblum, J.D., Professor, Georgetown University Law Center, Washington, DC  
James R. Winn, M.D., Executive Vice President, Federation of State Medical Boards,  
Ft. Worth, TX

**Definitions of HIV Disease: Policy Implications  
Washington, DC  
December 9-10, 1991**

**December 9**

Carol Levine, M.A., Executive Director, The Orphan Project, Fund for the City of New  
York, NY

***HIV Disease Definitions***

Ruth Berkelman, M.D., Chief, Surveillance Branch, Division of HIV/AIDS, Centers for  
Disease Control, Atlanta, GA  
Judith Cohen, Ph.D., Director, Association for Women's AIDS Research and Education,  
University of California, San Francisco, CA  
Jack Dehovitz, M.D., Director, AIDS Prevention Center, State University of New York,  
Health Science Center at Brooklyn, NY  
Don Des Jarlais, Ph.D., Director of Research, Beth Israel Medical Center, New York, and  
Commissioner, National Commission on AIDS

***Laboratory Implementation***

Stanley Inhorn, M.D., Medical Director, Wisconsin State Laboratory of Hygiene,  
Association of State and Territorial Laboratory Directors, Madison, WI  
J. Steven McDougal, M.D., Chief, Immunology Branch, Division of HIV/AIDS, Centers  
for Disease Control, Atlanta, GA

***Epidemiology and Surveillance***

Spencer Cox, Public Affairs Associate, Community Research Initiative on AIDS,  
New York, NY

David Fleming, M.D., Deputy State Epidemiologist, Oregon Department of Human  
Resources, Council of State and Territorial Epidemiologists, Portland, OR

George Lemp, Dr.P.H., Chief, HIV/AIDS Surveillance, AIDS Office, San Francisco  
Department of Public Health, San Francisco, CA

Maxine Wolfe, Ph.D., Professor of Psychology, City University of New York Graduate  
School, Brooklyn, NY

**December 10**

***Confidentiality and Civil Liberties Issues***

David Hansell, J.D., Deputy Executive Director for Policy, Gay Men's Health Crisis,  
New York, NY

Nancy Neveloff Dubler, LL.B., Director of Division of Law and Ethics, Montefiore  
Medical Center, Albert Einstein College of Medicine, Bronx, NY

Sallie Perryman, Special Assistant to the Director of Policy, New York State Department  
of Health AIDS Institute, New York, NY

***Implications for Care/Services***

G. Stephen Bowen, M.D, M.P.H, Director, Bureau of Health Resources Development,  
Health Resources and Services Administration, Rockville, MD

John T. Holloway, M.D., District Health Director, S.E. Health Unit, Waycross, GA

Ronald L. Johnson, Executive Director, Minority Task Force on AIDS, New York, NY

Theresa McGovern, J.D., Project Director, MFY HIV Project, New York, NY

Laura Thomas, ACT UP San Francisco, San Francisco HIV Services Planning Council,  
San Francisco, CA

***Benefits and Entitlements***

Rozann Abato, Deputy Director, Medicaid Bureau, Health Care Financing  
Administration, Baltimore, MD

Trish Butler, Assistant Commissioner of Public Affairs, Social Security Administration,  
Baltimore, MD

Philip J. Fornaci, J.D., Staff Attorney, Whitman Walker Clinic, Washington, DC

Arlene H. Gahan, Deputy Assistant Commissioner, Office of Disability, Social Security  
Administration, Baltimore, MD

Christine Reyelt, M.D., Medical Director, Comprehensive Care Center for AIDS, St.  
Joseph Hospital and Medical Center, Patterson, NJ



**The Future of the HIV Epidemic: The Potential for Change**  
**Washington, DC**  
**January 14, 1992**

***Epidemiology of HIV/AIDS***

James W. Curran, M.D., M.P.H., Assistant Surgeon General, Director, Division of HIV/AIDS, Centers for Disease Control, Atlanta, GA

Dixie E. Snider, Jr., M.D., M.P.H., Director, Division of Tuberculosis Elimination, Centers for Disease Control, Atlanta, GA

***Implications for the Future***

Jane L. Delgado, Ph.D., M.S., Chief Executive Officer, National Coalition of Hispanic Health and Human Services Organizations (COSMHO), Washington, DC

Ralph DiClemente, Ph.D., Center for AIDS Prevention Studies, University of California, San Francisco, CA

Jacob Gayle, Ph.D., Special Assistant for Minority and Other Special Populations, Office of the Deputy Director (HIV), Centers for Disease Control, on detail to The Carter Center, Atlanta, GA

Derek Hodel, Executive Director, People With AIDS Health Group, New York, NY

Janice Jirau, Washington, DC

Mark D. Smith, M.D., M.B.A., Vice President, The Henry J. Kaiser Family Foundation, Menlo Park, CA

**Housing Issues and the HIV Epidemic**  
**Boston, MA**  
**March 2-3, 1992**

**March 2**

Larry Kessler, Commissioner, National Commission on AIDS, Executive Director, AIDS Action Committee, Boston, MA

***Overview***

Robert L. Greenwald, Chief Policy and Legal Advisor, AIDS Action Committee, Boston, MA

Judith Kurland, Commissioner, Department of Health and Hospitals, Boston, MA

Betsy Lieberman, Executive Director, AIDS Housing of Washington, Seattle, WA

***People with Housing Needs***

Constance Amaral, Lynn, MA

Corring Amaral, Lynn, MA

Michael Cox, Cambridge Cares about AIDS, Cambridge, MA

Michael Cronin, Boston, MA

Jean Robert Desir, Health Educator, Cambridge Haitian American Association, Cambridge, MA

### **March 3**

Mayor Raymond L. Flynn, Boston, MA

#### ***The Federal Perspective***

Anna Kondratas, Assistant Secretary for Community Planning and Development,  
Department of Housing and Urban Development, Washington, DC

#### ***Defining the Continuum/Describing the Need***

Barbara Ann Chinn, Director, Schwartz Housing Service, Whitman Walker Clinic,  
Washington, DC

Virginia Shubert, Director of Advocacy and Public Policy, Housing Works, Inc.,  
New York, NY

Leo Teachout, Director, GROW, A Community Service Corporation, Wilmington, NC

### **Sex, Society, and the HIV Epidemic**

New Orleans, Louisiana

May 18-19, 1992

### **May 18**

Sheila Webb, Louisiana Mayor's Office, Baton Rouge, LA

#### ***Toward a National Prevention Strategy***

Thomas J. Coates, Ph.D., Director, The Center for AIDS Prevention Studies, San  
Francisco, CA

#### ***Research on Sexual Behavior: Implications for the HIV Epidemic***

John H. Gagnon, Ph.D., State University of New York at Stony Brook, New York, NY

#### ***Culture, Ethnicity, and Gender in Sex Research***

Vickie M. Mays, Ph.D., Department of Psychology, University of California,  
Los Angeles, CA

### **May 19**

#### ***Sex, Society, and HIV***

Priscilla Alexander, Global Programme on AIDS, World Health Organization, Geneva,  
Switzerland

Richard Green, M.D., J.D., University of California, Los Angeles, School of Medicine,  
Los Angeles, CA

John Money, Ph.D., Johns Hopkins University and Hospital, Baltimore, MD

Jose Pares-Avila, M.A., Clinical Psychology Fellow, Harvard Medical School,  
Boston, MA

Carole Vance, Ph.D., M.P.H., Columbia University School of Public Health,  
New York, NY

***Adolescents and Sexuality***

Tim Haas, Person Living with AIDS

Robert Selverstone, Ph.D., Board Member, Sex Information and Education Council of the U.S. (SIECUS), New York, NY

Walter Shervington, M.D., Assistant Secretary for Mental Health, State of Louisiana, Baton Rouge, LA

Pedro P. Zamora, The Body Positive Resource Center, Inc., Miami, FL

**Communications and the HIV Epidemic  
Kansas City, MO, and Kansas City, KS  
June 15-16, 1992**

**June 15**

***What is Communication and Why is it Relevant to the Epidemic?***

Mary D. Fisher, The Family AIDS Network, Boca Raton, FL

Robert Hornick, Ph.D., Annenberg School of Communication, University of Pennsylvania, Philadelphia, PA

***How are the Public Perceptions on HIV and AIDS Shaped?***

Mary Debus, Porter/Novelli, Washington, DC

Charles Eisendrath, M.A., University of Michigan, Ann Arbor, MI

Rita Lepicier, Executive Director, KCET Television, Los Angeles, CA

Theresa F. Rogers, Ph.D., Barnard College with Columbia University, New York, NY

Stephen B. Thomas, Ph.D., University of Maryland, College Park, MD

***What is the Role of Communication in Primary Prevention?***

Rashidah Hassan, R.N., Executive Director, BEBASHI, Philadelphia, PA

Ernesto Hinojos, M.P.H., Gay Men's Health Crisis, New York, NY

Jay T. Johnson, E.D., M.S.W., Topeka AIDS Project, Topeka, KS

Frederick C. Kroger, National AIDS Information and Education Program, Centers for Disease Control, Atlanta, GA

Michael Ramah, Porter/Novelli, AIDSCOM, Washington, DC

**June 16**

Honorable Joan Finney, Governor of Kansas

***Care-Oriented Communication Issues***

Mike Barr, AIDS Center, St. Vincent's Hospital, New York, NY

Lawrence S. Brown, M.D., M.P.H., Addiction Research and Treatment Corporation, Brooklyn, NY

John S. James, AIDS Treatment News, San Francisco, CA

Elena Perez, B.A., M.T., Center for Continuing Education in the Health Profession, Newark, NJ

Rochelle L. Rollins, M.P.H., Multi-Cultural AIDS Coalition, Boston, MA  
Leonard A. Simpson, M.D., American Association of Physicians for Human Rights, San Francisco, CA

**An Agenda for AIDS: Actions Needed in Early 1993**  
**Washington, DC**  
**November 17, 1992**

***Leadership of the National Response***

Joseph A. Califano, Jr., Chairman and President, Center on Addiction and Substance Abuse at Columbia University, New York, NY

***Mobilizing the Federal Government: Congress, Agencies, and Collaborative Efforts***

Joyce M. Bove, B.A., M.P.A., Chair and Founder, Funders Concerned About AIDS, Vice President, New York Community Trust/Community Funds, Inc., New York, NY

Daniel T. Bross, Co-Chair, National Organizations Responding to AIDS, Executive Director, AIDS Action Council, Washington, DC

M. Joycelyn Elders, M.D., President, Association of State and Territorial Health Officers, Washington, DC, Director, Arkansas Department of Health, Little Rock, AR

Mathilde Krim, M.D., Ph.D., Founding Co-Chair and Chairman of the Board, American Foundation for AIDS Research, New York, NY

Lee Smith, Chair, National Leadership Coalition on AIDS, Washington, DC, Corporate Vice President, Levi Strauss and Co.

***Supporting the Affected***

A. Cornelius Baker, Director, Public Policy and Education, National Association of People With AIDS, Washington, DC

Sandra L. Thurman, Executive Director, AIDS Atlanta, Inc., Atlanta, GA

***Prevention of HIV Transmission***

Sandra S. McDonald, Board Member, National Minority AIDS Council, Executive Director, Outreach Inc., Atlanta, GA

Yolanda Serrano, Executive Director, Association for Drug Abuse Prevention and Treatment (ADAPT), Bronx, NY

***Research***

Mark Harrington, Treatment Action Group (TAG), New York, NY

Robert L. Johnson, M.D., F.A.A.P., Department of Pediatrics, University of Medicine and Dentistry, Newark, NJ

**Prevention Strategies in the Workplace and Schools: Current Challenges**  
**Austin, TX**  
**March 10-11, 1993**

**March 10**

***Welcoming Remarks***

David R. Smith, M.D., Texas Commissioner of Health, Texas Department of Health,  
Austin, TX

***Behavioral Research and AIDS Prevention: Using the Workplace and Schools***

Anke Ehrhardt, Ph.D., American Psychological Association, Washington, DC  
Martin Fishbein, Ph.D., Professor of Psychology, University of Illinois, Urbana-  
Champaign, IL

***The CDC's Role in Prevention Education in the Workplace and Schools***

James W. Curran, M.D., M.P.H., Centers for Disease Control and Prevention,  
Atlanta, GA

***AIDS and the Workplace***

Sandy Bartlett, Coordinator, Central Texas AIDS in the Workplace Task Force,  
Austin, TX  
Erline Belton, The Lyceum Group, Cleveland, OH  
Jerald A. Breitman, Director, Professional Relations, Burroughs Wellcome Co., Research  
Triangle Park, NC  
Carol Camlin, Manager, AIDS Education at Work, AIDS Action Committee,  
Boston, MA  
Sharon F. Canner, Assistant Vice President, National Association of Manufacturers,  
Washington, DC  
Alan Emery, Ph.D., Consultant, San Francisco, CA  
Ledia Martinez, M.D., M.P.H., Office of HIV/AIDS Education, American Red Cross,  
Washington, DC  
Brenda Moon, The George Meany Center for Labor Studies, Washington, DC  
Barney Singer, J.D., Assistant Chief Counsel for Labor Policy, Small Business  
Administration, Washington, DC  
B.J. Stiles, President, National Leadership Coalition on AIDS, Washington, DC  
Benneville N. Strohecker, President, Harbor Sweets, Inc., Salem, MA

**March 11**

***Welcoming Remarks***

Honorable Glen Maxey, Representative, State of Texas

***School and Youth Prevention Strategies***

Kate Barnhart, Student, New York City Public Schools, Manhattan, NY  
Jay Coburn, B.S., Director, Training and Technical Assistance, Center for Population  
Options, Washington, DC

*The Final Report of the National Commission on AIDS*

*Appendix E-39*

Joanne G. Fraser, Ed.D., Director, HIV/AIDS School Health Education Project, South  
Carolina Department of Education, Columbia, SC  
Marion Howard, Ph.D., Clinical Director, Teen Services Program, Grady Memorial  
Hospital, Atlanta, GA  
Marvin Jeter, Teacher Living with AIDS  
Gene Wilhoit, Executive Director, National Association of State Boards of Education,  
Alexandria, VA

*Presentation by ACTT (Active Community Teen Theater), McAllen, TX*

## **APPENDIX F**

**PUBLIC LAW 100-607, NOVEMBER 4, 1988**

### **Subtitle D—National Commission on Acquired Immune Deficiency Syndrome**

#### **SEC.241. SHORT TITLE.**

This subtitle may be cited as the "National Commission on Acquired Immune Deficiency Syndrome Act."

#### **SEC.242. ESTABLISHMENT.**

There is established a commission to be known as the "National Commission on Acquired Immune Deficiency Syndrome" (hereinafter in this Act referred to as the "Commission").

#### **SEC.243. DUTIES OF THE COMMISSION.**

(a) **GENERAL PURPOSE OF THE COMMISSION.**—The Commission shall carry out activities for the purpose of promoting the development of a national consensus on policy concerning acquired immune deficiency syndrome (hereinafter in this subtitle referred to as "AIDS") and of studying and making recommendations for a consistent national policy concerning AIDS.

(b) **SUCCESSION.**—The Commission shall succeed the Presidential Commission on the Human Immunodeficiency Virus Epidemic, established by Executive Order 12601, dated June 24, 1987.

(c) **FUNCTIONS.**—The Commission shall perform the following functions:

(1) Monitor the implementation of the recommendations of the Presidential Commission on the Human Immunodeficiency Virus Epidemic, modifying those recommendations as the Commission considers appropriate.

(2) Evaluate the adequacy of, and make recommendations regarding, the financing of health care and research needs relating to AIDS, including the allocation of resources to various Federal agencies and State and local governments and the roles for and activities of private and public financing.

(3) Evaluate the adequacy of, and make recommendations regarding, the dissemination of information that is essential to the prevention of the spread of AIDS, and that recognizes the special needs of minorities and the important role

of the family, educational institutions, religion, and community organizations in education and prevention efforts.

(4) Address any necessary behavioral changes needed to combat AIDS, taking into consideration the multiple moral, ethical, and legal concerns involved, and make recommendations regarding testing and counseling concerning AIDS, particularly with respect to maintaining confidentiality.

(5) Evaluate the adequacy of, and make recommendations regarding, Federal and State laws on civil rights relating to AIDS.

(6) Evaluate the adequacy of, and make recommendations, regarding the capability of the Federal Government to make and implement policy concerning AIDS (and, to the extent feasible to do so, other diseases, known and unknown, in the future), including research and treatment, the availability of clinical trials, education and the financing thereof, and including specifically—

(A) the streamlining of rules, regulations, and administrative procedures relating to the approval by the Food and Drug Administration of new drugs and medical devices, including procedures for the release of experimental drugs; and

(B) the advancement of administrative consideration by the Health Care Financing Administration relating to reimbursement for new drugs and medical devices approved by the Food and Drug Administration.

(7) Evaluate the adequacy of, and make recommendations regarding, international coordination and cooperation concerning data collection, treatment modalities, and research concerning AIDS.

#### **SEC.243. DUTIES OF THE COMMISSION.**

##### **(a) NUMBER AND APPOINTMENT.—**

(1) Appointment.—The Commission shall be composed of 15 members as follows:

(A) Five members shall be appointed by the President—

(i) three of whom shall be—

(I) the Secretary of Health and Human Services;

(II) the Administrator of Veterans' Affairs; and

(III) the Secretary of Defense;

who shall be nonvoting members, except that, in the case of a tie vote by the Commission, the Secretary of Health and Human Services shall be a voting member; and

(ii) two of whom shall be selected from the general public on the basis of such individuals being specially qualified to serve on the Commission by reason of their education, training, or experience.

(B) Five members shall be appointed by the Speaker of the House of Representatives on the joint recommendation of the Majority and Minority Leaders of the House of Representatives.

(C) Five members shall be appointed by the President pro tempore of the Senate on the joint recommendation of the Majority and Minority Leader of the Senate.

(2) Congressional Committee Recommendations.—In making appointments under subparagraphs (B) and (C) of paragraph (1), the Majority and Minority Leaders of the House of Representatives and the Senate shall duly consider the recommendations of



the Chairmen and Ranking Minority Members of committees with jurisdiction over laws contained in chapter 17 of title 38, United States Code (relating to veterans' health care), title XIX of the Social Security Act (42 U.S.C. 1901 et seq.) (relating to Medicaid), and the Public Health Service Act (42 U.S.C. 201 et seq.) (relating to the Public Health Service).

(3) REQUIREMENTS OF APPOINTMENTS.—The Majority and Minority Leaders of the Senate and the House of Representatives shall—

(A) select individuals who are specially qualified to serve on the Commission by reason of their education, training, or experience; and

(B) engage in consultations for the purpose of ensuring that the expertise of the 10 members appointed by the Speaker of the House of Representatives and the President pro tempore of the Senate shall provide as much of a balance as possible and, to the greatest extent possible, cover the fields of medicine, science, law, ethics, health-care economics, and health-care and social services.

(4) TERM OF MEMBERS.—Members of the Commission (other than members appointed under paragraph (1)(A)(i)) shall serve for the life of the Commission.

(5) VACANCY.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made.

(b) CHAIRMAN.—Not later than 15 days after the members of the Commission are appointed, such members shall elect a Chairman from among the members of the Commission.

(c) QUORUM.—Seven members of the Commission shall constitute a quorum, but a lesser number may be authorized by the Commission to conduct hearings.

(d) MEETINGS.—The Commission shall hold its first meeting on a date specified by the Chairman, but such date shall not be earlier than September 1, 1988, and not be later than 60 days after the date of the enactment of this Act, or September 30, 1988, whichever is later. After the initial meeting, the Commission shall meet at the call of the Chairman or a majority of its members, but shall meet at least three times each year during the life of the Commission.

(e) PAY.—Members of the Commission who are officers or employees or elected officials of a government entity shall receive no additional compensation by reason of their services on the Commission.

(f) PER DIEM.—While away from their homes or regular places of business in the performance of duties for the Commission, members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under sections 5702 and 5703 of title 5, United States Code.

(g) DEADLINE FOR APPOINTMENT.—Not earlier than July 11, 1988, and not later than 45 days after the date of enactment of this Act, or August 1, 1988, whichever is later, the members of the Commission shall be appointed.

## SEC. 245. REPORTS.

(a) INTERIM REPORTS.—

(1) IN GENERAL.—Not later than 1 year after the date on which the Commission is fully constituted under section 244(a), the Commission shall prepare and submit to the President and to the appropriate committees of Congress a comprehensive report on the activities of the Commission to that date.

(2) CONTENTS.—The report submitted under paragraph (1) shall include such findings, and such recommendations for legislation and administrative action, as the Commission considers appropriate based on its activities to that date.

(3) OTHER REPORTS.—The Commission shall transmit such other reports as its considers appropriate.

(b) FINAL REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date on which the Commission is fully constituted under section 244(a), the Commission shall prepare and submit a final report to the President and to the appropriate committees of Congress.

(2) CONTENTS.—The final report submitted under paragraph (1) shall contain a detailed statement of the activities of the Commission and of the findings and conclusions of the Commission, including such recommendations for legislation and administrative action as the Commission considers appropriate.

#### **SEC.246. EXECUTIVE DIRECTOR AND STAFF.**

(a) EXECUTIVE DIRECTOR.—

(1) APPOINTMENT.—The Commission shall have an Executive Director who shall be appointed by the Chairman, with the approval of the Commission, not later than 30 days after the Chairman is selected.

(2) COMPENSATION.—The Executive Director shall be compensated at a rate not to exceed the maximum rate of basic pay payable under GS-18 of the General Schedule as contained in title 5, United States Code.

(b) STAFF.—With the approval of the Commission, the Executive Director may appoint and fix the compensation of such additional personnel as the Executive Director considers necessary to carry out the duties of the Commission.

(c) APPLICABILITY OF CIVIL SERVICE LAWS.—The Executive Director and the additional personnel of the Commission appointed under subsection (b) may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

(d) CONSULTANTS.—Subject to such rules as may be prescribed by the Commission, the Executive Director may procure temporary or intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals not to exceed \$200 per day.

(e) DETAILED PERSONNEL AND SUPPORT SERVICES.—Upon the request of the Commission for the detail of personnel, or for administrative and supportive services, to assist the Commission in carrying out its duties under this Act, the Secretary of Health and Human Services and the Administrator of Veterans' Affairs, either jointly or separately, may on a reimbursable basis (1) detail to the Commission personnel of the Department of Health and Human Services or the Veteran's Administration, respectively, or (2) provide to the Commission administrative and support services. The Secretary and the Administrator shall consult for the purpose of determining and implementing an appropriate method for jointly or separately detailing such personnel and providing such services.

#### **SEC.247. POWERS OF THE COMMISSION**

(a) HEARINGS.—For the purpose of carrying out this Act, the Commission may conduct such hearings, sit and act at such times and places, take testimony, and receive such

evidence, as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before the Commission.

(b) DELEGATION.—Any member or employee of the Commission may, if authorized by the Commission, take any action that the Commission is authorized to take under this Act.

(c) ACCESS TO INFORMATION.—The Commission may secure directly from any executive department or agency such information as may be necessary to enable the Commission to carry out this Act, except to the extent that the department or agency is expressly prohibited by law from furnishing such information. On the request of the Chairman of the Commission, the head of such department or agency shall furnish nonprohibited information to the Commission.

(d) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

#### **SEC.248. AUTHORIZATION OF APPROPRIATIONS**

There is authorized to be appropriated for fiscal year 1989 \$2,000,000, and such sums as may be necessary in any subsequent fiscal year, to carry out the purposes of this Act. Amounts appropriated pursuant to such authorization shall remain available until expended.

#### **SEC.249. TERMINATION**

(a) The Commission shall cease to exist 30 days after the date on which its final report is submitted under section 245(b). The President may extend the life of the Commission for a period of not to exceed 2 years.

## **APPENDIX G: Commissioner Biographies**

### **Members of the National Commission on AIDS**

Chairman **June E. Osborn, M.D.**, is Professor of Epidemiology and Dean of the School of Public Health at the University of Michigan; she is also Professor of Pediatrics and Communicable Diseases at the University of Michigan Medical School. She has served on numerous federal and nonfederal committees, including the Global Commission on AIDS for the World Health Organization, the Robert Wood Johnson Foundation National Advisory Committee for the AIDS Health Services Project (Chair), and the Steering Committee of the Global AIDS Policy Coalition. Dr. Osborn has published extensively in the fields of virology, public health, and public policy. She earned her M.D. at Case Western Reserve University School of Medicine, did her pediatric residency at Harvard Hospitals, and trained in virology and infectious diseases at Johns Hopkins University and at the University of Pittsburgh. She is a member of both the American Academy of Pediatrics and the American Academy of Microbiology. In 1986 she was elected to membership in the Institute of Medicine of the National Academy of Sciences.

Vice Chairman **David E. Rogers, M.D.**, completed his M.D. in 1948 at Cornell University and served an internship and residency at Johns Hopkins. Among his important appointments are those of Professor of Medicine at Vanderbilt, Dean of Medicine, and Vice President for Medical Affairs at Johns Hopkins University and Medical Director of the Johns Hopkins Hospital. Dr. Rogers was appointed the first Walsh McDermott University Professor of Medicine at the New York Hospital-Cornell University Medical Center in November 1986. For the 15 years preceding this appointment, Dr. Rogers was President of the Robert Wood Johnson Foundation in Princeton, New Jersey, the largest philanthropy devoting its resources to alleviating problems in the health care of Americans. Dr. Rogers has been very involved in the problems of AIDS, holding appointments as Chairman of the Advisory Council of the AIDS Institute of New York State, member of the Citizens Commission on AIDS of New York and New Jersey, Chair of the National Community AIDS Partnership, and Chair of the New York City Mayoral Task Force on AIDS.

**The Honorable Diane Ahrens** is presently serving her 19th year as Commissioner of Ramsey County, Minnesota. She chaired the Human Services Steering Committee of the National Association of Counties (NACo) from 1986 to 1988 and in 1988 was appointed chair of NACo's task force on HIV/AIDS, which formulated recommendations for all counties regarding their role in addressing the HIV epidemic. She earned her masters degree in religion and higher education at Yale University. For the past 25 years she has served on boards and commissions at the local, state, and national level, addressing health,

wellness, correctional, and social services issues. She speaks widely on these issues as well as on AIDS. In recognition of this service she has received numerous awards and honors.

**Reverend K. Scott Allen** works with the HIV/AIDS Research Group at the University of Texas Southwestern Medical School. He is an ordained Southern Baptist minister. Rev. Allen became personally involved in the HIV epidemic in 1985 after discovering his wife and two children were infected with HIV in 1982. Later, in 1987 his brother discovered he was infected with HIV. His youngest child died of AIDS in February 1986. His first wife died of AIDS in February 1992. Rev. Allen has worked extensively with the spiritual, ethical, and psychological dimensions of AIDS through pastoral care, local and state governments, and community-based organizations.

**Don C. Des Jarlais, Ph.D.**, is currently Director of Research for the Chemical Dependency Institute of Beth Israel Medical Center, Senior Research Fellow, Deputy Director for AIDS Research with the National Development and Research Institutes, Inc., and Professor of Community Medicine at Mount Sinai School of Medicine. He is an international leader in the fields of AIDS and intravenous drug use and during the past seven years has published numerous scientific articles on those topics. He was the plenary speaker on intravenous drug use and AIDS at the 3rd, 4th, and 7th International Conferences on AIDS. He chairs the Committee on Behavioral, Social, and Statistical Sciences of the National Academy of Sciences. He also serves as a consultant to various institutions, including the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, and the World Health Organization. He is a Guest Investigator at Rockefeller University and a Visiting Professor of Psychology at Columbia University. Dr. Des Jarlais earned his doctorate of philosophy in social psychology from the University of Michigan.

**Eunice Diaz, Ph.D., M.P.H.**, is former Vice Chair of the Health Resources and Services Administration (HRSA) AIDS Advisory Council and a member of the Secretary's Task Force on Infant Mortality (HHS) as a health consultant. She is a nationally known expert and speaker on the issue of AIDS in the Hispanic community, and a former Vice Chair of AIDS Project Los Angeles. In addition, Ms. Diaz has served on numerous AIDS-related committees and panels, including the Los Angeles County Commission on AIDS, the Planning Committee for the Surgeon General's Conference on Pediatric AIDS, and, most recently, the Surgeon General's National Hispanic Health Initiative. She has received numerous awards and recognition for her work in AIDS with the Hispanic media and with religious communities. Ms. Diaz earned her master of science in public health and master of public health at Loma Linda University. She has also received an honorary Ph.D. from Atlantic Union College in Lancaster, Massachusetts.

**Mary D. Fisher** is founder and member of the Family AIDS Network, Inc., a nonprofit organization that supports her role as an HIV/AIDS spokesperson by expanding the network of concerned individuals and organizations through national and regional awareness-building events. She made public her HIV status in February 1992 and joined the effort to increase recognition of the epidemic and concern for families most affected by it. In 1974 she gained national prominence with her appointment as the first woman

"advance man" for the White House, working directly with President Gerald R. Ford. She attended the Cranbrook Academies, Oakland Community College, Wayne State University, and the University of Michigan. Her professional career began when she produced the first three PBS television auctions at WTVS in Detroit. She then spent two years producing a live morning show for Detroit's ABC-owned-and-operated WXYZ-TV. Ms. Fisher founded a cottage industry for handmade American crafts in the late 1970s. In the early 1980s she began studying the process of handmade paper, and today her handmade paper pieces are featured at the Helander Galleries in New York and Palm Beach and in distinguished collections.

**Donald S. Goldman, Esq.**, is an attorney and was a partner in the West Orange, New Jersey, law firm of Harkavy, Goldman, Goldman & Caprio. Active in the National Hemophilia Foundation and its chapters for over 25 years, he served as Chairman from 1983 to 1984 and President from 1984 to 1986. Mr. Goldman coordinated the National Hemophilia Foundation's efforts to improve the safety of the nation's blood supply, began many of its efforts in HIV risk reduction, and introduced initiatives to improve delivery of hemophilia and HIV services to minorities. Mr. Goldman earned his J.D. from Rutgers University and has published and lectured widely on legal aspects of hemophilia, HIV infection, and other medical and ethical issues. He is admitted to the bar of New Jersey, the United States Court of Appeals for the Third Circuit, and the United States Supreme Court.

**Larry Kessler** is a founding member and Executive Director of the AIDS Action Committee of Massachusetts, New England's largest and oldest AIDS service organization. Beginning in 1983 as its only paid staff member, Kessler organized a corps of volunteers to combat the AIDS epidemic through education, service, advocacy, and outreach. He now oversees a staff of 95 full-time employees and more than 2,500 volunteers who provide support services to more than 1,400 men and women living with AIDS and HIV and educational programs for health care providers, the public, and communities at risk of HIV infection. Kessler continues to play a leading role in advocating on the federal, state, and local levels for fair and effective AIDS policy and funding. He was an original member of the Massachusetts Governor's Task Force on AIDS and the Boston Mayor's Task Force on AIDS, under appointments by Governor Michael S. Dukakis and Mayor Raymond Flynn, respectively. Kessler is a founding board member of the former National AIDS Network and the AIDS Action Council in Washington, on whose board he continues to serve. He also served on the Advisory Board of the Harvard AIDS Institute and is a board member of the National Leadership Coalition on AIDS. In 1987, Simmons College in Boston awarded him an honorary degree of doctor of human services. In 1992 Salem State College awarded him an honorary degree of doctor in humane letters.

**Charles Konigsberg, M.D., M.P.H.**, is currently serving as Director of Public Health for the Delaware Department of Health and Social Services. His previous positions include Director of Health for the Kansas Department of Health and Environment and local health director positions in Florida, Tennessee, and Alabama. As Director of the Broward County Health Unit for the Florida Department of Health and Rehabilitative Services from 1984 to 1988, Dr. Konigsberg served as a member of Governor Graham's AIDS Advisory Task Force and was instrumental in developing a comprehensive AIDS

clinic for Broward County. Dr. Konigsberg represented the local public health perspective on AIDS at numerous CDC and other meetings and conferences, including the 1986 Coolfont Conference. He earned his M.D. from the University of Tennessee Center for the Health Sciences and his master of public health from the University of North Carolina School of Public Health.

**The Honorable J. Roy Rowland, M.D.**, is now serving his sixth term in the U.S. House of Representatives (Democrat, Georgia's Eighth Congressional District). As the only physician in Congress from 1985 to 1988, Congressman Rowland has provided leadership and insight on a number of health issues, such as infant mortality, rural health, the veterans' health system, and AIDS. His efforts on behalf of the AIDS community include sponsoring the legislation that authorized creation of the National Commission on AIDS and introducing a bill mandating study of AIDS among college students—an idea that was adopted administratively by the Centers for Disease Control. Congressman Rowland earned his M.D. from the Medical College of Georgia and maintained a family practice in central Georgia for three decades before pursuing a political career.

#### **Cabinet Members**

**Les Aspin, Ph.D.**, Secretary of Defense, represented the First District of Wisconsin in the U.S. House of Representatives from 1971 to 1993 and became Chairman of the House Armed Services Committee in 1985. Before his election to Congress, Mr. Aspin, an economist, served on President Kennedy's Council of Economic Advisers.

**Jesse Brown**, Secretary of Veterans Affairs, who is a combat-disabled Vietnam veteran, worked for many years for the one-million-member Disabled American Veterans (DAV). In 1989 he was appointed Executive Director of the DAV and has managed the Washington office, supervising the DAV's national service, legislative, employment, and volunteer programs.

**Donna E. Shalala, Ph.D.**, Secretary of Health and Human Services, became President of Hunter College of New York in 1980 and Chancellor of the University of Wisconsin at Madison in 1988. From 1975 to 1977, Secretary Shalala was Director of the Municipal Assistance Corporation, which was the agency that helped reverse New York City's financial collapse. She served President Jimmy Carter as Assistant Secretary for Policy Development and Research in the Department of Housing and Urban Development from 1977 to 1980. She is also a former member of the board and Chairman of the Children's Defense Fund, and a former Peace Corps volunteer to Iran.

#### **Former Members**

**Richard B. Cheney** was nominated by President Bush to be Secretary of Defense on March 10, 1989, was confirmed by the United States Senate on March 17, 1989, and took the oath of office on March 21, 1989. In August 1974, when Gerald R. Ford assumed the presidency, Mr. Cheney served on the Ford transition team, beginning in September 1974



as a Deputy Assistant to the President. In November 1975 he was named Assistant to the President and White House Chief of Staff, a position he held through the remainder of the Ford Administration, until January 1977. He returned to his home state of Wyoming in May 1977 to resume private life. Mr. Cheney was elected to Congress in November 1978. He was reelected in 1980, 1982, 1984, 1986, and 1988.

**Harlon L. Dalton, Esq.**, is a Professor at Yale Law School and a leading authority on legal issues generated by the AIDS epidemic. His AIDS-related publications include *AIDS and the Law: A Guide for the Public*, and "AIDS in Blackface." Mr. Dalton serves on the AIDS Interfaith Network in New Haven (Chairperson), the Advisory Board of the Connecticut Consortium of AIDS, the Editorial Board of the AIDS Alert, and the New Haven Mayor's Task Force on AIDS. He earned his J.D. from Yale Law School. Mr. Dalton served as a member of the Commission from August 1989 to January 1993.

**Edward J. Derwinski**, President Bush's choice to become the first Secretary of the newly created cabinet-level Department of Veterans Affairs, was confirmed by the Senate on March 2, 1989, and sworn in on March 15, 1989. Secretary Derwinski directed the activities of the federal government's second largest department, responsible for a nationwide system of health care services and benefits programs for America's 27.3 million veterans. A member of the U.S. House of Representatives from 1959 to 1983, representing Illinois' Fourth Congressional District, he was the senior minority member of the House Foreign Affairs Committee, Post Office Committee, and Civil Service Committee. He played a major role in the passage of landmark civil service reform, postal service reorganization, and foreign service reform legislation.

**Earvin "Magic" Johnson, Jr.**, left a remarkable career in the National Basketball Association on November 7, 1991, with the announcement that he had tested positive for the HIV virus. Since his retirement, he has founded the Magic Johnson Foundation, Inc., and joined the battle against the HIV epidemic. He has numerous business interests and endorsements nationally and around the world. He maintains an active interest and involvement with several charities, including the United Negro College Fund, Muscular Dystrophy, City of Hope, American Heart Association, and many others. Mr. Johnson served on the Commission from November 1991 to September 1992.

**Belinda Ann Mason** was a journalist, fiction writer, and powerful voice for all persons affected by HIV. Ms. Mason, who died of AIDS, served as a member of the Commission from August 1989 to September 1991. She founded the first organization in Kentucky and Indiana for people with HIV disease and was the Chair Emeritus of the National Association of People with AIDS. Her strong mind and spirit were of immeasurable value to the work of the Commission.

**Louis W. Sullivan, M.D.**, was sworn in as Secretary of Health and Human Services on March 10, 1989. As head of the Department of Health and Human Services, Dr. Sullivan oversaw the federal agency responsible for the major health, welfare, food and drug safety, medical research, and income security programs serving the American people. Dr. Sullivan came to HHS from the Morehouse School of Medicine in Atlanta, Georgia. In July 1975 Dr. Sullivan became founding dean and director of the medical education



program at Morehouse College. In July 1, 1981, when the School of Medicine became independent from Morehouse College, he served as its first Dean and President. In April 1985 the Morehouse School of Medicine was fully accredited and on May 17, 1985 the school awarded the M.D. degree to its first 16 graduates.